



IOWA ADMINISTRATIVE BULLETIN

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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]; workers' compensation rate filings [515A.6(7)]; usury rates [535.2(3)"a"]; and agricultural credit corporation maximum loan rates [535.12].

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, lettered paragraph, or numbered subparagraph).

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)

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 Rule Making 2013

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
Dec. 19 '12	Jan. 9 '13	Jan. 29 '13	Feb. 13 '13	Feb. 15 '13	Mar. 6 '13	Apr. 10 '13	July 8 '13
Jan. 4	Jan. 23	Feb. 12	Feb. 27	Mar. 1	Mar. 20	Apr. 24	July 22
Jan. 18	Feb. 6	Feb. 26	Mar. 13	Mar. 15	Apr. 3	May 8	Aug. 5
Feb. 1	Feb. 20	Mar. 12	Mar. 27	Mar. 29	Apr. 17	May 22	Aug. 19
Feb. 15	Mar. 6	Mar. 26	Apr. 10	Apr. 12	May 1	June 5	Sep. 2
Mar. 1	Mar. 20	Apr. 9	Apr. 24	Apr. 26	May 15	June 19	Sep. 16
Mar. 15	Apr. 3	Apr. 23	May 8	May 10	May 29	July 3	Sep. 30
Mar. 29	Apr. 17	May 7	May 22	***May 22***	June 12	July 17	Oct. 14
Apr. 12	May 1	May 21	June 5	June 7	June 26	July 31	Oct. 28
Apr. 26	May 15	June 4	June 19	***June 19***	July 10	Aug. 14	Nov. 11
May 10	May 29	June 18	July 3	July 5	July 24	Aug. 28	Nov. 25
May 22	June 12	July 2	July 17	July 19	Aug. 7	Sep. 11	Dec. 9
June 7	June 26	July 16	July 31	Aug. 2	Aug. 21	Sep. 25	Dec. 23
June 19	July 10	July 30	Aug. 14	Aug. 16	Sep. 4	Oct. 9	Jan. 6 '14
July 5	July 24	Aug. 13	Aug. 28	***Aug. 28***	Sep. 18	Oct. 23	Jan. 20 '14
July 19	Aug. 7	Aug. 27	Sep. 11	Sep. 13	Oct. 2	Nov. 6	Feb. 3 '14
Aug. 2	Aug. 21	Sep. 10	Sep. 25	Sep. 27	Oct. 16	Nov. 20	Feb. 17 '14
Aug. 16	Sep. 4	Sep. 24	Oct. 9	Oct. 11	Oct. 30	Dec. 4	Mar. 3 '14
Aug. 28	Sep. 18	Oct. 8	Oct. 23	***Oct. 23***	Nov. 13	Dec. 18	Mar. 17 '14
Sep. 13	Oct. 2	Oct. 22	Nov. 6	***Nov. 6***	Nov. 27	Jan. 1 '14	Mar. 31 '14
Sep. 27	Oct. 16	Nov. 5	Nov. 20	***Nov. 20***	Dec. 11	Jan. 15 '14	Apr. 14 '14
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PRINTING SCHEDULE FOR IAB

<u>ISSUE NUMBER</u>	<u>SUBMISSION DEADLINE</u>	<u>ISSUE DATE</u>
18	Friday, February 15, 2013	March 6, 2013
19	Friday, March 1, 2013	March 20, 2013
20	Friday, March 15, 2013	April 3, 2013

PLEASE NOTE:

Rules will not be accepted after **12 o'clock noon** on the Friday filing deadline days unless prior approval has been received from the Administrative Rules Coordinator's office.

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

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

ENVIRONMENTAL PROTECTION COMMISSION[567]

Underground storage tanks—leak detection at unstaffed facilities, 135.5(1)“e” IAB 1/9/13 ARC 0560C (See also ARC 0559C)	Conference Rooms 5E/5W Wallace State Office Bldg. Des Moines, Iowa	February 7, 2013 1:30 p.m.
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IOWA PUBLIC EMPLOYEES’ RETIREMENT SYSTEM[495]

Contribution rates; coverage; administration, 4.6, 5.2(33), 11.5(2), 12.5, 12.6, 13.2, 15.2, 16.2 IAB 2/6/13 ARC 0598C	7401 Register Dr. Des Moines, Iowa	February 26, 2013 9 a.m.
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LABOR SERVICES DIVISION[875]

Federal occupational safety and health standards, 10.20, 26.1 IAB 2/6/13 ARC 0587C	Capitol View Room 1000 East Grand Ave. Des Moines, Iowa	March 13, 2013 10 a.m. (If requested)
Conveyance safety program—50-percent rule, fees, amendments to ch 71 IAB 2/6/13 ARC 0597C	Capitol View Room 1000 East Grand Ave. Des Moines, Iowa	March 7, 2013 10 a.m. (If requested)

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Center for congenital and inherited disorders, 4.1 to 4.5, 4.7, 4.11 to 4.14 IAB 1/23/13 ARC 0572C	Participation by conference call Dial: 1-866-685-1580 Enter pass code: 5152816466# at prompt (Call 1-800-383-3826 if problems occur.)	February 12, 2013 9 to 10 a.m.
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TRANSPORTATION DEPARTMENT[761]

Fitness to drive determinations by qualified medical professionals, 4.9(25), 600.1, 600.4(4), 605.5(5) IAB 1/23/13 ARC 0571C	Motor Vehicle Division Offices 6310 SE Convenience Blvd. Ankeny, Iowa	February 14, 2013 10 a.m. (If requested)
Federal motor carrier safety and hazardous materials regulations, 520.1(1) IAB 2/6/13 ARC 0591C	Motor Vehicle Division Offices 6310 SE Convenience Blvd. Ankeny, Iowa	February 28, 2013 10 a.m. (If requested)

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“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.

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ARC 0575C**HUMAN SERVICES DEPARTMENT[441]****Notice of Intended Action**

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 225C.6(1) and 2012 Iowa Acts, chapter 1120, section 38, the Department of Human Services proposes to amend Chapter 25, “Disability Services Management,” Iowa Administrative Code.

These amendments establish criteria for exempting counties from joining into regions to administer mental health and disability services. The Department is charged with implementing the redesign of the mental health and disability services system into a regionally administered, locally delivered service system. The authority to accept applications for an exemption is repealed effective July 1, 2013.

The Department was given emergency rule-making authority due to the requirements in the Iowa Code for counties to voluntarily form mental health and disability services regions by April 1, 2013, or submit a letter of intent by May 1, 2013, to apply for an exemption from forming into a region of at least three contiguous counties.

These amendments were also Adopted and Filed Emergency and are published herein as **ARC 0576C**. The purpose of this Notice is to solicit comment on that submission, the subject matter of which is incorporated by reference.

Any interested person may make written comments on the proposed amendments on or before February 26, 2013. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because the legislation does not specifically allow for waivers. Requests for the waiver of any rule may be submitted under the Department’s general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 331.389.

ARC 0589C**HUMAN SERVICES DEPARTMENT[441]****Notice of Intended Action**

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” Iowa Administrative Code.

This Notice of Intended Action is a companion to the Notice of Intended Action that proposes amendments to Chapter 79 and is published herein as **ARC 0588C**. Together, these Notices are the second set of changes to the unit time and rate definitions for home- and community-based services

HUMAN SERVICES DEPARTMENT[441](cont'd)

(HCBS) waiver and habilitation services. The first set was published in the Iowa Administrative Bulletin as **ARC 0567C** and **ARC 0568C** on January 23, 2013.

These amendments change billing codes used by Iowa Medicaid Enterprise (IME) from atypical, state-created codes to nationally recognized codes. These amendments also provide standardization of service definitions amongst the HCBS waivers. Finally, these amendments clarify the wording of some service definitions.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), no state Medicaid department can use atypical billing codes. (See 45 CFR 162.1000 and 162.1002.) Most of the codes used to bill waiver services to the IME are atypical and therefore need to be changed to standardized healthcare common procedure coding system (HCPCS) or current procedural terminology (CPT) codes. Those standardized codes have different unit descriptions from the unit descriptions currently contained in Chapter 78. For example, the atypical billing code unit definition is one hour; the new conversion code has a unit definition of 15 minutes.

The standardization and clarification of service definitions will provide continuity amongst the waiver programs and clearer definition of the service for the member, provider, and state. The description of each waiver service will now be the same for all waiver programs, unless a waiver has a very specific exception.

Any interested person may make written comments on the proposed amendments on or before February 26, 2013. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because the Centers for Medicare and Medicaid Services (CMS) has not indicated that any state can be exempt from the guidelines relating to atypical billing codes. The Department does not see any reason why any provider type would be exempt from adherence to CMS guidelines. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

The following amendments are proposed.

ITEM 1. Amend subparagraph **78.27(10)“a”(1)** as follows:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. and 2. No change.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is ~~an hour~~ 15 minutes. A maximum of ~~26~~ 104 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

HUMAN SERVICES DEPARTMENT[441](cont'd)

ITEM 2. Amend subrule 78.34(5) as follows:

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. and b. No change.

c. A unit of service is ~~one hour~~ 15 minutes.

d. No change.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in ~~rule 441—83.1(249A)~~ 441—Chapter 83.

f. and g. No change.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

ITEM 3. Amend subrule 78.34(8) as follows:

78.34(8) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. to c. No change.

d. Limitations.

(1) A maximum of 12 ~~one-hour units~~ hours of service is available per day.

(2) to (6) No change.

e. A unit of service is ~~one hour~~ 15 minutes.

ITEM 4. Amend subrule 78.37(6) as follows:

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. and b. No change.

c. A unit of service is ~~one hour~~ 15 minutes.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A). Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. and g. No change.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

ITEM 5. Amend subrule 78.38(5) as follows:

78.38(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. and b. No change.

HUMAN SERVICES DEPARTMENT[441](cont'd)

- c. A unit of service is ~~one hour~~ 15 minutes.
- d. ~~The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A). Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.~~
- e. ~~When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.~~
- f. and g. No change.
- h. ~~Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer directed attendant care provider for the member. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.~~

ITEM 6. Amend subrule 78.41(1) as follows:

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

- a. No change.
- b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.
- (1) No change.
- (2) Supported community living services shall be available at ~~an hourly~~ a 15-minute rate to members for whom a daily rate is not established.
- c. to e. No change.
- f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:
- (1) No change.
- (2) ~~One hour~~ Fifteen minutes when subparagraph 78.41(1)"f"(1) does not apply.
- g. The maximum number of units available per member is as follows:
- (1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.
- (2) ~~5,110 hourly~~ 20,440 15-minute units are available per state fiscal year except a leap year when ~~5,124 hourly~~ 20,496 15-minute units are available.
- h. and i. No change.

ITEM 7. Amend subrule 78.41(2) as follows:

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. and b. No change.
- c. A unit of service is ~~one hour~~ 15 minutes.

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~~d. Payment for respite services shall not exceed \$7,050 per the member's waiver year. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.~~

~~e. The service shall be identified in the member's individual comprehensive plan. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.~~

~~f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.~~

~~g. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.~~

~~h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A). Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.~~

~~i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed. Payment for respite services shall not exceed \$7,050 per the member's waiver year.~~

~~j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.~~

ITEM 8. Strike “consumer,” “consumers,” and “consumer’s” where appropriate in subrules **78.41(7)**, **78.41(14)** and **78.43(4)** and insert “member,” “members,” or “member’s” in lieu thereof as the context requires.

ITEM 9. Amend subparagraph **78.41(7)“a”(3)** as follows:

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the ~~consumer~~ member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the ~~consumer's~~ member's employment goals. A unit of service is ~~an hour~~ 15 minutes. A maximum of ~~26~~ 104 units may be provided in a 12-month period. The services provided may include:

1. to 3. No change.

ITEM 10. Amend paragraph **78.41(7)“b”** as follows:

b. Supports to maintain employment.

(1) and (2) No change.

(3) A unit of service is ~~one hour~~ 15 minutes.

(4) A maximum of ~~40~~ 160 units may be received per week.

ITEM 11. Amend subrule 78.41(9) as follows:

78.41(9) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are

HUMAN SERVICES DEPARTMENT[441](cont'd)

not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. to c. No change.

d. Limitations.

(1) A maximum of 12 ~~one-hour units~~ hours of service is available per day.

(2) to (6) No change.

e. A unit of service is ~~one hour~~ 15 minutes.

ITEM 12. Amend paragraph **78.41(13)**“c” as follows:

c. A unit of service is a full day (4 4.25 to 8 hours), ~~a half day (1 to 4 hours)~~, or an hour (for up to 4 hours per day).

ITEM 13. Amend subrule 78.41(14) as follows:

78.41(14) *Day habilitation services.*

a. No change.

b. *Family training option.* Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the ~~consumer's member's~~ member's home. The unit of service is ~~an hour~~ 15 minutes. The units of services payable are limited to a maximum of ~~10 hours~~ 40 units per month.

c. *Unit of service.* Except as provided in paragraph 78.41(14)“b,” the unit of service ~~may be an hour, a half day (1 to 4 hours)~~, is 15 minutes (for up to 16 units per day) or a full day (4 4.25 to 8 hours per day).

d. No change.

ITEM 14. Amend subrule 78.43(2) as follows:

78.43(2) *Supported community living services.* Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. No change.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) No change.

(2) Supported community living services shall be available at ~~an hourly~~ a 15-minute rate to members for whom a daily rate is not established.

c. and d. No change.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) No change.

(2) ~~One hour~~ Fifteen minutes when subparagraph 78.43(2)“e”(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) ~~8,395 hourly~~ 33,580 15-minute units ~~are available~~ per state fiscal year except a leap year, when ~~8,418 hourly~~ 33,672 15-minute units are available.

g. and h. No change.

HUMAN SERVICES DEPARTMENT[441](cont'd)

ITEM 15. Amend subrule 78.43(3) as follows:

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. and b. No change.

c. A unit of service is ~~one hour~~ 15 minutes.

d. No change.

e. ~~Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.~~

f. ~~The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A). A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.~~

g. ~~A maximum of 14 consecutive days of 24-hour respite care may be reimbursed. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.~~

h. ~~Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.~~

ITEM 16. Amend subparagraph **78.43(4)“a”(3)** as follows:

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the ~~consumer member~~ for a minimum of 30 days or with assisting the ~~consumer member~~ in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the ~~consumer's member's~~ employment goals. A unit of service is ~~an hour~~ 15 minutes. A maximum of ~~26~~ 104 units may be provided in a 12-month period. The services provided may include:

1. to 3. No change.

ITEM 17. Amend paragraph **78.43(4)“b”** as follows:

b. Supports to maintain employment.

(1) and (2) No change.

(3) A unit of service is ~~one hour~~ 15 minutes.

(4) A maximum of ~~40~~ 160 units may be received per week.

ITEM 18. Amend paragraph **78.43(11)“c”** as follows:

c. A unit of service is a full day (~~4-4.25 to 8 hours per day~~), ~~a half day (1 to 4 hours)~~, or an hour (for up to 4 hours per day).

ITEM 19. Amend subrule 78.43(14) as follows:

78.43(14) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. to c. No change.

d. Limitations.

(1) A maximum of 12 ~~one-hour units~~ hours of service is available per day.

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(2) to (6) No change.

e. A unit of service is ~~one hour~~ 15 minutes.

ITEM 20. Amend subrule 78.52(3) as follows:

78.52(3) Family and community support services. Family and community support services shall support the ~~consumer member~~ and the ~~consumer's member's~~ family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the ~~consumer's member's~~ and the family's social and emotional strength.

a. Dependent on the needs of the ~~consumer member~~ and the ~~consumer's member's~~ family members individually or collectively, family and community support services may be provided to the ~~consumer member~~, to the ~~consumer's member's~~ family members, or to the ~~consumer member~~ and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the ~~consumer's member's~~ interdisciplinary team pursuant to 441—83.127(249A) 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the ~~consumer member~~ and for the ~~consumer's member's~~ family.

(2) Modeling and coaching effective coping strategies for the ~~consumer's member's~~ family members.

(3) Building resilience to the stigma of serious emotional disturbance for the ~~consumer member~~ and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the ~~consumer's member's~~ crisis intervention plan as defined in 441—24.1(225C) for life situations with the ~~consumer's member's~~ family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the ~~consumer's member's~~ positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per ~~consumer member~~ per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must ~~identify~~ have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the ~~consumer's member's~~ service plan.

(3) The ~~consumer's member's~~ parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the ~~consumer member~~ or the ~~consumer's member's~~ family or legal guardian.

(4) The ~~consumer's member's~~ Medicaid ~~targeted~~ case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

~~(6) Family and community support services providers shall maintain records to:~~

~~1. Ensure that the transportation and therapeutic resources provided to not exceed the maximum amount authorized; and~~

~~2. Support the annual reporting requirements in 441—subparagraph 79.1(15)“a”(1).~~

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e. The following components are specifically excluded from family and community support services:

- (1) to (5) No change.
- (6) General supervision and consumer care.

f. A unit of family and community support services is ~~one hour~~ 15 minutes.

ITEM 21. Amend subrule 78.52(5) as follows:

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The “usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member. The purpose of respite care is to enable the member to remain in the member’s current living situation.

a. Respite care shall not be provided to members during the hours in which the usual caregiver is employed, except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care. Respite services provided outside the member’s home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.

c. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions: A unit of service is 15 minutes.

(1) ~~Basic individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.~~

(2) ~~Specialized respite is provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.~~

(3) ~~Group respite is provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.~~

d. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care.

e. Respite services provided outside the member’s home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A unit of service is one hour. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

ARC 0588C**HUMAN SERVICES DEPARTMENT[441]****Notice of Intended Action**

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” Iowa Administrative Code.

This Notice of Intended Action and the Notice of Intended Action published herein as **ARC 0589C** comprise the second set of changes to the unit time and rate definitions for home- and community-based service (HCBS) waiver and habilitation services. The first set of amendments to affect these changes for HCBS waivers was published in the Iowa Administrative Bulletin as **ARC 0567C** and **ARC 0568C** on January 23, 2013.

These amendments are needed to align reimbursement with new billing code definitions caused by conversion of atypical, state-created codes to nationally recognized codes. Current unit rates have been mathematically adjusted to match the new unit rate (i.e., an hourly rate was divided by 4 to create a 15-minute rate). In addition, these amendments increase rates to equalize service rates across programs (i.e., prevocational habilitation from \$9.91 to \$13.47 per hour). Finally, these amendments change the basis of reimbursement for respite from a retrospectively limited prospective rate to a fee schedule.

The Department is proposing these amendments pursuant to direction from the Centers for Medicare and Medicaid Services (CMS) and The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which states that no state Medicaid department can use atypical billing codes. Most of the codes used to bill waiver services to the Iowa Medicaid Enterprise (IME) are atypical and therefore need to be changed to standardized healthcare common procedure coding system (HCPCS) or current procedural terminology (CPT) codes. Those standardized codes have different unit descriptions from the unit descriptions currently used by the IME. These amendments to rule 441—79.1(249A) will cause the rates of reimbursement to match the unit definitions of the services. For example, the rate of reimbursement for a service that will be defined as 15 minutes will be expressed as a 15-minute rate instead of as an hourly rate.

The Department has determined that moving the retrospectively limited prospective rates for respite to a fee schedule will increase standardization within the service since many respite providers are already paid by fee schedule.

Any interested person may make written comments on the proposed amendments on or before February 26, 2013. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because CMS has not indicated that any state can be exempt from the guidelines relating to atypical billing codes. Requests for the waiver of any rule may be submitted under the Department’s general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

The following amendments are proposed.

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ITEM 1. Amend subrule **79.1(2)**, provider category “HCBS waiver service providers,” paragraphs “6,” “18,” “19,” “23,” “24,” “26” and “28,” as follows:

Provider category	Basis of reimbursement	Upper limit
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 1/1/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, <u>converted to a 15-minute rate</u> . If no 6/30/12 rate: Lesser of maximum Medicare rate in effect 11/30/09 plus 2%, <u>converted to a 15-minute rate</u> , or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly a 15-minute rate, not to exceed \$302.88 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 1/1/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, <u>converted to a 15-minute rate</u> . If no 6/30/12 rate: Lesser of maximum Medicare rate in effect 11/30/09 plus 2%, <u>converted to a 15-minute rate</u> , or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly a 15-minute rate, not to exceed \$302.88 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 1/1/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, <u>converted to a 15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour \$3.35 per 15-minute unit, not to exceed \$302.88 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 1/1/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, <u>converted to a 15-minute rate</u> . If no 6/30/12 rate: \$34.43 per hour \$8.61 per 15-minute unit, not to exceed \$302.88 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 1/1/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, <u>converted to a 15-minute rate</u> . If no 6/30/12 rate: \$18.37 per hour \$4.59 per 15-minute unit, not to exceed \$302.88 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 1/1/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, <u>converted to a 15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour \$3.35 per 15-minute unit, not to exceed \$302.88 per day.

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Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$34.43 per hour <u>\$8.61 per 15-minute unit</u> , not to exceed \$302.88 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$18.37 per hour <u>\$4.59 per 15-minute unit</u> , not to exceed \$302.88 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per 15-minute unit</u> , not to exceed \$302.88 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per 15-minute unit</u> , not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per 15-minute unit</u> , not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15) Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per 15-minute unit</u> , not to exceed \$302.88 per day.
Adult day care	Fee schedule	Effective 4/4/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per 15-minute unit</u> , not to exceed rate for regular adult day care services.

HUMAN SERVICES DEPARTMENT[441](cont'd)

Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 4/4/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per</u> 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 4/4/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per</u> 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 4/4/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per</u> 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 4/4/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a 15-minute rate. If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per</u> 15-minute unit, not to exceed contractual daily rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 4/4/13 For intellectual disability and brain injury waiver effective 7/1/13: \$35.68 <u>\$8.92 per 15-minute</u> unit, not to exceed the maximum daily ICF/ID rate per day in effect 6/30/12 plus 2%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$927.18 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$927.18 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 4/4/13 7/1/13: \$35.68 <u>\$8.92 per 15-minute</u> unit. Maximum of 26 hours <u>104</u> units per 12 months.

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Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 4/1/13 <u>7/1/13</u> : \$35.68 per hour <u>\$8.92 per 15-minute unit</u> for all activities other than personal care and services in an enclave setting. \$20.21 per hour <u>\$5.05 per 15-minute unit</u> for personal care. \$6.31 per hour <u>\$1.58 per 15-minute unit</u> for services in an enclave setting. \$2,941.38 per month for total service. Maximum of 40 <u>160</u> units per week.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 4/1/13 <u>7/1/13</u> : Lesser of provider's rate in effect 6/30/12 plus 2%, \$49.18 per day, \$24.59 per half day , or \$13.47 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 4/1/13 <u>7/1/13</u> : Lesser of maximum Medicare rate in effect 11/30/09 plus 2% ₂ converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly <u>a 15-minute</u> rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 4/1/13 <u>7/1/13</u> : Lesser of maximum Medicare rate in effect 11/30/09 plus 2% ₂ converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly <u>a 15-minute</u> rate.
Child development home or center	Fee schedule	Effective 4/1/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2% ₂ converted to a 15-minute rate. If no 6/30/12 rate: \$13.38 per hour <u>\$3.35 per 15-minute unit</u> .
Supported community living provider	Retrospectively limited prospective rate	Effective 4/1/13 <u>7/1/13</u> , provider's rate in effect 6/30/12 plus 2% ₂ converted to a 15-minute rate. If no 6/30/12 rate: \$35.68 per hour <u>\$8.92 per 15-minute unit</u> , not to exceed the maximum ICF/ID rate per day in effect 6/30/12 plus 2%.
26. Day habilitation	Fee schedule	Effective 4/1/13 <u>7/1/13</u> : County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/12 plus 2% ₂ converted to a 15-minute or daily rate. If no 6/30/12 rate: \$13.47 per hour , <u>\$3.37 per 15-minute unit</u> \$32.79 per half day , or \$65.58 per day.

HUMAN SERVICES DEPARTMENT[441](cont'd)

28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 4/4/13 7/1/13, provider's rate in effect 6/30/12 plus 2%, converted to a <u>15-minute rate</u> . If no 6/30/12 rate: \$35.68 per hour <u>\$8.92 per 15-minute unit</u> .
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ITEM 2. Amend subrule **79.1(2)**, provider category "Home- and community-based habilitation services," paragraphs "2" to "5," as follows:

Provider category	Basis of reimbursement	Upper limit
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$46.70 per hour <u>\$11.68 per 15-minute unit</u> , not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$13.21 per hour , <u>\$3.30 per 15-minute unit</u> \$32.15 per half-day , or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$9.91 per hour , <u>\$13.47 per hour</u> , \$24.11 per half-day , or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: Maximum of \$34.98 per hour <u>\$8.75 per 15-minute unit</u> and 26 hours <u>104 units</u> per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	Effective 7/1/13: \$6.19 per hour <u>\$1.55 per 15-minute unit</u> for services in an enclave setting; \$19.81 per hour <u>\$4.95 per 15-minute unit</u> for personal care; and \$34.98 per hour <u>\$8.75 per 15-minute unit</u> for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 <u>160</u> units per week.

ITEM 3. Amend subrule 79.1(15) as follows:

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; ~~HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.~~

a. and b. No change.

c. *Prospective rates for new providers other than respite.*

(1) to (3) No change.

d. *Prospective rates for established providers other than respite.*

HUMAN SERVICES DEPARTMENT[441](cont'd)

(1) to (5) No change.

~~e.—Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph “f.”~~

f. and g. No change.

ITEM 4. Amend paragraph 79.1(24)“a” as follows:

a. *Units of service.*

(1) No change.

(2) A unit of home-based habilitation is ~~one hour (for up to 7 hours per day)~~ a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for ~~hourly~~ services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The ~~hourly~~ 15-minute unit shall be used when the member receives services for ~~1 to 7 hours~~ 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. No change.

(3) A unit of day habilitation is ~~an hour, a half day (1 to 4 hours),~~ 15 minutes (up to 16 units per day) or a full day (4 4.25 to 8 hours).

(4) A unit of prevocational habilitation is ~~an hour, a half day (1 to 4 hours),~~ (for up to 4 units per day) or a full day (4 4.25 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. ~~One hour~~ A 15-minute unit for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is ~~one hour~~ a 15-minute unit.

ARC 0584C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” Iowa Administrative Code.

The Health Care and Education Reconciliation Act of 2010 (HCERA), Section 1202 (Public Law 111-152) (42 U.S.C. § 1396a(a)(13)(C)), requires that state Medicaid programs increase payments to primary care specialties specified under Section 1202 of the Act. In particular, HCERA identifies the following specialty designations: “family medicine,” “general internal medicine,” and “pediatric medicine.” The payment requirement specifies that reimbursement must be “... at a rate not less than 100 percent of the payment under part B of title XVIII [Medicare].” Section 1202 of the Act also specifies the types of services that fall under this requirement. Those services include: (1) services designated as “evaluation and management” under the healthcare common procedure coding system (HCPCS), as of December 31, 2009 (and subsequently modified), which are current procedural terminology (CPT) codes in the (“evaluation and management”) range 99201-99499; and (2) services

HUMAN SERVICES DEPARTMENT[441](cont'd)

related to immunization administration, billed with current CPT codes 90460, 90461, 90471, 90472, 90473 and 90474.

Section 1202 of the Act also requires that these same changes be made for Medicaid managed care plans. In that regard, such changes are being effectuated by contract amendments with the current (and only) medical managed care plan administered by Meridian Health Plan. Beyond Meridian, there are no other managed care plans that would be affected. Because these changes are being addressed via contract amendment, there are no changes being made to managed care rules under 441—Chapter 88.

Section 1202 of the Act specifies that these increased payments are only to be in effect for calendar years 2013 and 2014.

Final regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) allow for two criteria to identify the applicable practitioners meeting the requirements of Section 1202 of the Act:

1. The first method is board certification by the national specialty boards applicable to each specified group (i.e., the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA)).

2. The second method is claims history of at least 60 percent of a given practitioner's Medicaid claims attributable to the primary care services (i.e., procedure codes) specified under Section 1202 of the Act.

Providers must certify that they meet one or both of these criteria.

These amendments were also Adopted and Filed Emergency and are published herein as **ARC 0585C**. The purpose of this Notice is to solicit comment on that submission, the subject matter of which is incorporated by reference.

Any interested person may make written comments on the proposed amendments on or before February 26, 2013. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

These amendments do not provide for waivers in specified situations because the amendments confer a benefit of increased payment to identified primary care providers specified under Section 1202 of the Act. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, there is a potential for positive impact on private sector jobs. According to CMS, "the overall benefit of this rule is the expected increase in provider participation [in Medicaid] by primary care physicians resulting in better access to primary and preventive health services by Medicaid beneficiaries" 77 Fed. Reg. 66670 (Nov. 6, 2012). On that basis, there will be a positive impact on private sector jobs and employment opportunities for primary care physicians and associated personnel.

These amendments are intended to implement Iowa Code section 249A.4.

ARC 0590C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"b."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 81, "Nursing Facilities," Iowa Administrative Code.

This amendment allows nursing facilities to collect additional payment above the Medicaid payment from residents and families who desire a private room. Current rules do not allow supplementation of

HUMAN SERVICES DEPARTMENT[441](cont'd)

the rate for a private room. Iowa Code section 249A.4(10) makes this allowable when certain conditions are met.

Any interested person may make written comments on the proposed amendment on or before February 26, 2013. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

Specific waivers are not provided because the Department has an established procedure for considering exceptions to policy. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

This amendment is intended to implement Iowa Code section 249A.4.

The following amendment is proposed.

Adopt the following **new** subparagraph **81.10(5)“e”(4)**:

(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(c)(8)(ii).

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 80 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 inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;

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

- The private rooms for which supplementation is available, including a description and identification of such rooms; and

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

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

- A description and identification of the private room for which the nursing facility is receiving supplementation;

- The identity of the individual making the supplemental payments;

- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and

HUMAN SERVICES DEPARTMENT[441](cont'd)

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

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

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

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

ARC 0601C**INSPECTIONS AND APPEALS DEPARTMENT[481]****Notice of Intended Action**

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 10A.104(5) and 135C.14, the Department of Inspections and Appeals hereby gives Notice of Intended Action to amend Chapter 22, “Health Care Facility Audits,” Chapter 50, “Health Care Facilities Administration,” Chapter 54, “Governor’s Award for Quality Care,” Chapter 57, “Residential Care Facilities,” Chapter 58, “Nursing Facilities,” and Chapter 65, “Intermediate Care Facilities for Persons with Mental Illness (ICF/PMI),” Iowa Administrative Code.

The proposed amendments strike the terms “mental retardation” and “mentally retarded” from the Department’s administrative rules and replace them with the term “intellectually disabled.” The proposed amendments make corresponding changes in the Department’s administrative rules to implement sections 11 through 18 of 2012 Iowa Acts, chapter 1019.

The Department does not believe that the proposed amendments impose any financial hardships on any regulated entity, body, or individual. Rather, the proposed amendments simply make corrective changes regarding individuals with intellectual disabilities.

The State Board of Health reviewed the proposed amendments at its January 9, 2013, meeting.

Any interested person may make written suggestions or comments on the proposed amendments on or before February 26, 2013. Such written material should be addressed to the Director, Department of Inspections and Appeals, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0083; faxed to (515)242-6863; or e-mailed to david.werning@dia.iowa.gov.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement 2012 Iowa Acts, chapter 1019, sections 11 to 18.

The following amendments are proposed.

ITEM 1. Amend rule 481—22.1(10A) as follows:

481—22.1(10A) Audit occurrence. The department audits financial records of intermediate care facilities, residential care facilities, and intermediate care facilities for the ~~mentally retarded~~ intellectually disabled on a rotating basis or upon request of the department of human services (DHS). Audits are intended to ensure compliance with the following Iowa Administrative Code chapters:

1. 441—Chapter 52, Payment, specifically subrule 52.1(3).
2. 441—Chapter 54, Facility Participation, specifically rule 441—54.5(249) and subrule 54.8(2).
3. 441—Chapter 81, ~~Intermediate Care~~ Nursing Facilities, specifically subrule 81.4(3), rule 441—81.10(249A) and subrule 81.14(2).

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

4. 441—Chapter 82, Intermediate Care Facilities for ~~the Mentally Retarded~~ Persons with an Intellectual Disability, specifically subrules 82.9(3) and 82.17(2).

If a rule not listed is used in an audit, the auditor will notify the facility.

The department acts as an agent for DHS when conducting the above audits.

~~This rule is intended to implement Iowa Code sections 10A.302(2) and 10A.302(3).~~

ITEM 2. Amend subrule 50.3(3) as follows:

50.3(3) Standards used to determine whether a license is granted or retained are found in the rules of the department of inspections and appeals in the Iowa Administrative Code as follows:

- a. Hospitals, 481—Chapter 51;
- b. Hospices, 481—Chapter 53;
- c. Residential care facilities, 481—Chapters 57 and 60;
- d. Nursing facilities, 481—Chapters 58 and 61;
- e. Residential care facilities for persons with mental illness, 481—Chapters 60 and 62;
- f. Residential care facilities for the ~~mentally retarded~~ intellectually disabled, 481—Chapters 60 and 63;
- g. Intermediate care facilities for the ~~mentally retarded~~ intellectually disabled, 481—Chapter 64; and
- h. Intermediate care facilities for persons with mental illness, 481—Chapter 65.

ITEM 3. Amend rule ~~481—54.2(135C)~~, definition of “Health care facility,” as follows:

“*Health care facility*” or “*facility*” means residential care facilities, nursing facilities, intermediate care facilities for persons with mental illness, and intermediate care facilities for persons with ~~mental retardation~~ an intellectual disability licensed pursuant to Iowa Code chapter 135C.

ITEM 4. Amend subrule 57.1(15) as follows:

57.1(15) “*Qualified mental retardation professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with ~~the mentally retarded~~ persons with an intellectual disability.

ITEM 5. Amend rule 481—57.4(135C) as follows:

481—57.4(135C) Special categories. Special variations and considerations may be granted a residential care facility which is operated for people who have special problems such as ~~retardation~~ intellectual disabilities, physical disabilities, have a physical or mental disability or a condition in common which can best be treated in a specialized environment under an approved program of care commensurate with the needs of the residents of the facility. Criteria for these specialized programs shall be established by the department based on the résumé of programs and services furnished by the facility and the numbers and qualifications of the administrator and staff providing these services in the facility.

57.4(1) No change.

57.4(2) On approval of the department, the state fire marshal, the department of ~~social~~ human services, or other appropriate agencies, other variations from the established rules and regulations and standards for a licensed health care facility of that category may be made as is necessary to successfully implement the specialized program, providing that it does not endanger the health, safety, or welfare of any resident and that alternate means to effect the same degree of protection shall be used when such variances are permitted.

ITEM 6. Amend paragraph **57.35(6)“c”** as follows:

c. A statement shall be signed by the resident, or the resident’s responsible party, if applicable, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. In the case of a ~~mentally retarded~~ an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 7. Amend subrule 57.35(8) as follows:

57.35(8) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the ~~department of health and human services~~ U.S. Department of Health and Human Services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or ~~mentally-retarded~~ intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or ~~mentally-retarded~~ intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

ITEM 8. Amend subrule 57.38(3) as follows:

57.38(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code subsection 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or ~~mentally-retarded~~ intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

ITEM 9. Amend rule **481—58.1(135C)**, definition of "Qualified mental retardation professional," as follows:

"Qualified mental retardation professional" means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year's experience working with ~~the mentally-retarded~~ persons with an intellectual disability.

ITEM 10. Amend paragraph **58.39(7)"c"** as follows:

c. A statement shall be signed by the resident, or the resident's responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of a ~~mentally-retarded~~ an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 11. Amend subrule 58.39(9) as follows:

58.39(9) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services' protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or ~~mentally retarded~~ intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or ~~mentally retarded~~ intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. The resident's plan of care shall be based on the physician's orders. It shall be developed upon admission by appropriate facility staff and shall include participation by the resident if capable. Residents shall be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives shall be elicited and honored if feasible.

e. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

ITEM 12. Amend subrule 58.42(3) as follows:

58.42(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or ~~mentally retarded~~ intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

ITEM 13. Amend rule 481—58.43(135C), introductory paragraph, as follows:

481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of a ~~mentally retarded~~ an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified mental retardation professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 14. Amend subrule 58.43(8), introductory paragraph, as follows:

58.43(8) In the case of a ~~mentally retarded~~ intellectually disabled individual who participates in a behavior modification program involving use of restraints or aversive stimuli, the program shall be conducted only with the informed consent of the individual's parent or responsible party. Where restraints are employed, an individualized program shall be developed by the interdisciplinary team with specific methodologies for monitoring its progress. (II)

ITEM 15. Amend rule ~~481—65.1(135C)~~, definition of "Commission," as follows:

"*Commission*" means the mental health and ~~mental retardation~~ disability services commission.

ITEM 16. Amend paragraph **65.4(2)"e"** as follows:

e. Obtain approval of the Iowa mental health and ~~mental retardation~~ disability services commission, when the request is for a variance from the requirement for qualification of a mental health professional.

ARC 0600C

INSPECTIONS AND APPEALS DEPARTMENT[481]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)"b."

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 10A.104(5) and 135C.14, the Department of Inspections and Appeals hereby gives Notice of Intended Action to amend Chapter 63, "Residential Care Facilities for the Mentally Retarded," Iowa Administrative Code.

The proposed amendments strike the terms "mental retardation" and "mentally retarded" from the Department's administrative rules and replace them with the terms "intellectually disabled" and "intellectual disabilities," as appropriate. The proposed amendments makes corresponding changes in the Department's administrative rules to implement sections 11 through 18 of 2012 Iowa Acts, chapter 1019.

The Department does not believe that the proposed amendments impose any financial hardships on any regulated entity, body, or individual. Rather, the proposed amendments simply make corrective changes regarding individuals with intellectual disabilities.

The State Board of Health reviewed the proposed amendments at its January 9, 2013, meeting.

Any interested person may make written suggestions or comments on the proposed amendments on or before February 26, 2013. Such written material should be addressed to the Director, Department of Inspections and Appeals, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0083; faxed to (515)242-6863; or e-mailed to david.werning@dia.iowa.gov.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement 2012 Iowa Acts, chapter 1019.

The following amendments are proposed.

ITEM 1. Amend **481—Chapter 63**, title, as follows:

RESIDENTIAL CARE FACILITIES FOR THE
~~MENTALLY RETARDED~~ INTELLECTUALLY DISABLED

ITEM 2. Amend subrules 63.1(2), 63.1(9) and 63.1(16) as follows:

63.1(2) "*Administrator*" means a person who administers, manages, supervises, and is in general administrative charge of a residential care facility for the ~~mentally retarded~~ intellectually disabled, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

63.1(9) “*Distinct part*” means a clearly identifiable area or section within a residential care facility for the ~~mentally-retarded~~ intellectually disabled, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

63.1(16) “*Qualified mental retardation professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with the ~~mentally-retarded~~ intellectually disabled.

ITEM 3. Amend rule 481—63.2(135C), introductory paragraph, as follows:

481—63.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility for the ~~mentally-retarded~~ intellectually disabled. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

ITEM 4. Amend subrule 63.3(1), introductory paragraph, as follows:

63.3(1) Initial application and licensing. In order to obtain an initial residential care facility for the ~~mentally-retarded~~ intellectually disabled license; for a residential care facility for the ~~mentally-retarded~~ intellectually disabled which is currently licensed, the applicant must:

ITEM 5. Amend paragraph **63.3(1)“f”** as follows:

f. Submit the statutory fee for a residential care facility for the ~~mentally-retarded~~ intellectually disabled for which licensure application is made;

ITEM 6. Amend subrule 63.3(2), introductory paragraph, as follows:

63.3(2) In order for a facility not currently licensed as a residential care facility for the intellectually disabled to obtain an initial license as a residential care facility for the ~~mentally-retarded~~ intellectually disabled license for a facility not currently licensed as a residential care facility for the ~~mentally-retarded~~ intellectually disabled, the applicant must:

ITEM 7. Amend paragraphs **63.3(2)“d”** to **“f”** as follows:

d. Submit a floor plan of each floor of the residential care facility for the ~~mentally-retarded~~ intellectually disabled, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the room will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the residential care facility for the ~~mentally-retarded~~ intellectually disabled;

f. Submit the statutory fee for a residential care facility for the ~~mentally-retarded~~ intellectually disabled;

ITEM 8. Amend subrule 63.3(3) as follows:

63.3(3) Renewal application. In order to obtain a renewal of the residential care facility for the ~~mentally-retarded~~ intellectually disabled license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of residential care facility for the ~~mentally-retarded~~ intellectually disabled license;

b. Submit the statutory license fee for a residential care facility for the ~~mentally-retarded~~ intellectually disabled with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program and other services.

ITEM 9. Amend subrule 63.4(3) as follows:

63.4(3) The posted license shall accurately reflect the current status of the residential care facility for the ~~mentally-retarded~~ intellectually disabled. (III)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 10. Amend subrules 63.5(2) to 63.5(4) and 63.5(7) as follows:

63.5(2) Of any proposed change in the residential care facility for the ~~mentally retarded's~~ intellectually disabled's functional operation or addition or deletion of required services; (III)

63.5(3) Thirty days before addition, alteration, or new construction is begun in the residential care facility for the ~~mentally retarded~~ intellectually disabled, or on the premises; (III)

63.5(4) Thirty days in advance of closure of the residential care facility for the ~~mentally retarded~~ intellectually disabled; (III)

63.5(7) Prior to the purchase, transfer, assignment, or lease of a residential care facility for the ~~mentally retarded~~ intellectually disabled, the licensee shall:

- a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)
- b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)
- c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility for the ~~mentally retarded~~ intellectually disabled to the named prospective purchaser, transferee, assignee, or lessee; (III)

ITEM 11. Amend subrule 63.5(8) as follows:

63.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility for the ~~mentally retarded~~ intellectually disabled, the department shall upon request, send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

ITEM 12. Amend rule 481—63.8(135C), introductory paragraph, as follows:

481—63.8(135C) Administrator. Each residential care facility for the ~~mentally retarded~~ intellectually disabled shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

ITEM 13. Amend paragraph **63.8(1)“c”** as follows:

c. Have completed a one-year educational training program approved by the department for residential care facility for the ~~mentally retarded~~ intellectually disabled. (III)

ITEM 14. Amend subrule 63.8(2), introductory paragraph, as follows:

63.8(2) The administrator may act as an administrator for not more than two residential care facilities for the ~~mentally retarded~~ intellectually disabled. (II)

ITEM 15. Amend subrule 63.8(4) as follows:

63.8(4) A provisional administrator may be appointed on a temporary basis by the residential care facility for the ~~mentally retarded~~ intellectually disabled licensee to assume the administrative responsibilities for a residential care facility for the ~~mentally retarded~~ intellectually disabled for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator, provided the department has been notified prior to the date of the administrator's appointment. (III)

ITEM 16. Amend paragraphs **63.8(6)“a”** and **“c”** as follows:

a. Assume the responsibility for the overall operation of the residential care facility for the ~~mentally retarded~~ intellectually disabled; (III)

c. Establish written policies, which shall be available for review, for the operation of the residential care facility for the ~~mentally retarded~~ intellectually disabled. (III)

ITEM 17. Amend paragraph **63.8(7)“d”** as follows:

d. Make available the residential care facility for the ~~mentally retarded~~ intellectually disabled payroll records for departmental review as needed. (III)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 18. Amend subrules 63.9(8) and 63.9(9) as follows:

63.9(8) The residential care facility for the ~~mentally-retarded~~ intellectually disabled shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

63.9(9) Each facility licensed as a residential care facility for the ~~mentally-retarded~~ intellectually disabled shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

ITEM 19. Amend paragraphs **63.11(1)“a”** and **“b”** as follows:

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility for the ~~mentally-retarded~~ intellectually disabled. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility for the ~~mentally-retarded~~ intellectually disabled. (II)

ITEM 20. Amend paragraphs **63.11(2)“a”** and **“b”** as follows:

a. The department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility for the ~~mentally-retarded~~ intellectually disabled, using as its criteria the services being offered as indicated on the résumé program of care and, as required for individual care plans, the needs of the resident. (II, III)

b. Personnel in a residential care facility for the ~~mentally-retarded~~ intellectually disabled shall provide 24-hour coverage for residential care services for the ~~mentally-retarded~~ intellectually disabled. Personnel shall be up and dressed at all times in facilities ~~over~~ with more than 15 beds. In facilities with 15 or ~~less~~ fewer beds, personnel shall be up and dressed when residents are awake. (II, III)

ITEM 21. Amend paragraphs **63.13(1)“a”** and **“b,” “e” to “g”** and **“i”** as follows:

a. No resident who is in need of greater services than the facility can provide shall be admitted or retained in a residential care facility for the ~~mentally-retarded who is in need of greater services than the facility can provide~~ intellectually disabled. (II, III)

b. No residential care facility for the ~~mentally-retarded~~ intellectually disabled shall admit more residents than the number of beds for which it is licensed. (II, III)

e. The admission of a resident to a residential care facility for the ~~mentally-retarded~~ intellectually disabled shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the residential care facility for the ~~mentally-retarded~~ intellectually disabled the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the residential care facility for the ~~mentally-retarded~~ intellectually disabled as required by these rules. (III)

g. A residential care facility for the ~~mentally-retarded~~ intellectually disabled shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

i. Funds or properties received by the residential care facility for the ~~mentally-retarded~~ intellectually disabled, belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

ITEM 22. Amend paragraph **63.13(2)“b”** as follows:

b. Proper arrangements shall be made by the residential care facility for the ~~mentally-retarded~~ intellectually disabled for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 23. Amend subrules 63.15(1), 63.15(2), 63.15(6) and 63.15(7) as follows:

63.15(1) Each resident in a residential care facility for the ~~mentally-retarded~~ intellectually disabled shall have a designated licensed physician, who may be called when needed. (III)

63.15(2) Each resident admitted to a residential care facility for the ~~mentally-retarded~~ intellectually disabled shall have had a physical examination prior to admission. If the resident is admitted directly from another health care facility, a copy of the admission physical and discharge summary may be part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be part of the resident's record. (III)

a. and b. No change.

63.15(6) Each resident shall be visited by or shall visit the resident's physician at least annually. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility for the ~~mentally-retarded~~ intellectually disabled may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

63.15(7) Residents shall be admitted to a residential care facility for the ~~mentally-retarded~~ intellectually disabled only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

ITEM 24. Amend subrule 63.16(1) as follows:

63.16(1) The residential care facility for the ~~mentally-retarded~~ intellectually disabled personnel shall assist residents to obtain regular and emergency dental services. (III)

ITEM 25. Amend subrule 63.17(1), introductory paragraph, as follows:

63.17(1) *Resident record.* The licensee shall keep a permanent record on all residents admitted to a residential care facility for the ~~mentally-retarded~~ intellectually disabled with all entries current, dated, and signed. (III) The record shall include:

ITEM 26. Amend paragraph **63.17(2)“a”** as follows:

a. Each residential care facility for the ~~mentally-retarded~~ intellectually disabled shall maintain an incident record report and shall have available incident report forms. (III)

ITEM 27. Amend paragraph **63.18(1)“c”** as follows:

c. Bulk supplies of prescription drugs shall not be kept in a residential care facility for the ~~mentally-retarded~~ intellectually disabled unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

ITEM 28. Amend paragraph **63.18(3)“f”** as follows:

f. In an ~~RCF/MR~~ RCF/ID facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

ITEM 29. Amend subrule 63.21(2), introductory paragraph, as follows:

63.21(2) Each residential care facility for the ~~mentally-retarded~~ intellectually disabled shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

ITEM 30. Amend paragraph **63.21(3)“a”** as follows:

a. Each residential care facility for the ~~mentally-retarded~~ intellectually disabled with over 15 beds shall employ a person to direct the activities program. (III)

ITEM 31. Amend rule 481—63.23(135C), introductory paragraph, as follows:

481—63.23(135C) Safety. The licensee of a residential care facility for the ~~mentally-retarded~~ intellectually disabled shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

ITEM 32. Amend paragraph **63.23(1)“a”** as follows:

a. All residential care facilities for the ~~mentally-retarded~~ intellectually disabled shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 33. Amend subrule 63.31(1) as follows:

63.31(1) A residential care facility for the ~~mentally-retarded~~ intellectually disabled shall be constructed in a neighborhood free from excessive noise, dirt, polluted or odorous air, or similar disturbances. (III)

ITEM 34. Amend paragraph **63.33(6)“c”** as follows:

c. A statement shall be signed by the resident, or responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of a ~~mentally-retarded~~ an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

ITEM 35. Amend subrule 63.33(8), introductory paragraph, as follows:

63.33(8) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the ~~department of health and human services~~ U.S. Department of Health and Human Services' protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or ~~mentally-retarded~~ intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

ITEM 36. Amend paragraph **63.33(8)“c”** as follows:

c. If the physician determines or in the case of a confused or ~~mentally-retarded~~ intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

ITEM 37. Amend subrule 63.36(3) as follows:

63.36(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or ~~mentally-retarded~~ intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

ITEM 38. Amend rule 481—63.47(135C), introductory paragraph, as follows:

481—63.47(135C) Specialized license for three- to five-bed facilities. The specialized license is for residential care facilities which serve persons with ~~mental-retardation~~ intellectual disabilities, chronic mental illness and other developmental disabilities having five or fewer residents as specified in Iowa Code section 225C.26. The facility is exempt from Iowa Code section 135.63. For this specialized license, all rules of 481—Chapter 63 apply except those which are deleted or amended, as indicated in subsequent rules.

ITEM 39. Amend paragraph **63.47(1)“f”** as follows:

f. Unless documented as appropriate within the residents' individual program plans, populations with primary diagnosis of chronic mental illness or ~~mental-retardation~~ intellectual disability/developmental disability may not be residents of the same specialized license facility. (II, III)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 40. Amend subrule 63.47(2) as follows:

63.47(2) The housing for persons with ~~mental retardation~~ intellectual disabilities, chronic mental illness, and other developmental disabilities, developed pursuant to this rule shall be eligible for funding utilized by licensed residential care facilities for the ~~mentally retarded~~ intellectually disabled.

ITEM 41. Amend subrule **63.47(7)**, numbered paragraphs “**3**” and “**28**,” as follows:

3. 63.8(2)—Add “For purposes of the specialized license, the administrator may act as an administrator for not more than three residential care facilities for the ~~mentally retarded~~ intellectually disabled, chronic mentally ill, and developmentally disabled.” (II)

28. 63.33(8)“c”—Delete “in the case of a confused or ~~mentally retarded~~ intellectually disabled resident”. Change any reference of “responsible party” to “legal guardian”.

ITEM 42. Amend subrule 63.47(9), introductory paragraph, as follows:

63.47(9) “~~Mental retardation~~” “Intellectual disabilities” as used in this chapter shall also include the chronically mentally ill and the developmentally disabled for purposes of this specialized license.

ITEM 43. Amend paragraph **63.47(9)“a,”** introductory paragraph, as follows:

a. For the specialized license, “persons with ~~mental retardation~~ intellectual disabilities” means persons with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period.

ITEM 44. Amend rule 481—63.48(135C) as follows:

481—63.48(135C) County care facilities. In addition to Chapter 63 licensing rules, county care facilities licensed as residential care facilities for the ~~mentally retarded~~ intellectually disabled must also comply with department of human services rules, Iowa Administrative Code 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to Iowa Administrative Code 481—56.2(135C).

ARC 0599C

INSPECTIONS AND APPEALS DEPARTMENT[481]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 10A.104(5) and 135C.14, the Department of Inspections and Appeals hereby gives Notice of Intended Action to amend Chapter 64, “Intermediate Care Facilities for the Mentally Retarded,” Iowa Administrative Code.

The proposed amendments strike the terms “mental retardation” and “mentally retarded” from the Department’s administrative rules and replace them with the terms “intellectually disabled” and “intellectual disabilities,” as appropriate. The proposed amendments make corresponding changes in the Department’s administrative rules to implement sections 11 through 18 of 2012 Iowa Acts, chapter 1019.

The Department does not believe that the proposed amendments impose any financial hardships on any regulated entity, body, or individual. Rather, the proposed amendments simply make corrective changes regarding individuals with intellectual disabilities.

The Board of Health reviewed the proposed amendments at its January 9, 2013, meeting.

Any interested person may make written suggestions or comments on the proposed amendments on or before February 26, 2013. Such written material should be addressed to the Director, Department

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

of Inspections and Appeals, Lucas State Office Building, 321 East 12th Street, Des Moines, Iowa 50319-0083; faxed to (515)242-6863; or e-mailed to david.werning@dia.iowa.gov.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement 2012 Iowa Acts, chapter 1019.

The following amendments are proposed.

ITEM 1. Amend **481—Chapter 64**, title, as follows:

INTERMEDIATE CARE FACILITIES FOR THE
~~MENTALLY RETARDED~~ INTELLECTUALLY DISABLED

ITEM 2. Amend rule 481—64.2(135C), introductory paragraph, as follows:

481—64.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual intermediate care facility for the ~~mentally retarded~~ intellectually disabled. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

ITEM 3. Amend subrule 64.3(1), introductory paragraph, as follows:

64.3(1) Initial application. In order to obtain an initial intermediate care facility for the ~~mentally retarded~~ intellectually disabled license for an intermediate care facility for the ~~mentally retarded~~ intellectually disabled which is currently licensed, the applicant must:

ITEM 4. Amend paragraphs **64.3(1)“d”** and **“e”** as follows:

d. Submit a photograph of the front and side elevation of the intermediate care facility for the ~~mentally retarded~~ intellectually disabled;

e. Submit the statutory fee for an intermediate care facility for the ~~mentally retarded~~ intellectually disabled license;

ITEM 5. Amend subrule 64.3(2), introductory paragraph, as follows:

64.3(2) In order to obtain an initial intermediate care facility for the ~~mentally retarded~~ intellectually disabled license for a facility not currently licensed as an intermediate care facility for the ~~mentally retarded~~ intellectually disabled, the applicant must:

ITEM 6. Amend paragraphs **64.3(2)“d,” “e”** and **“f”** as follows:

d. Submit a floor plan of each floor of the intermediate care facility for the ~~mentally retarded~~ intellectually disabled, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the rooms will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the intermediate care facility for the ~~mentally retarded~~ intellectually disabled;

f. Submit the statutory fee for an intermediate care facility for the ~~mentally retarded~~ intellectually disabled;

ITEM 7. Amend subrule 64.3(3), introductory paragraph, as follows:

64.3(3) Renewal application. In order to obtain a renewal of the intermediate care facility for the ~~mentally retarded~~ intellectually disabled license, the applicant must:

ITEM 8. Amend paragraphs **64.3(3)“a”** and **“b”** as follows:

a. Submit the completed application form 30 days prior to annual license renewal date of intermediate care facility for the ~~mentally retarded~~ intellectually disabled license;

b. Submit the statutory license fee for an intermediate care facility for the ~~mentally retarded~~ intellectually disabled with the application for renewal;

ITEM 9. Amend subrule 64.4(3) as follows:

64.4(3) The posted license shall accurately reflect the current status of the intermediate care facility for the ~~mentally retarded~~ intellectually disabled. (III)

INSPECTIONS AND APPEALS DEPARTMENT[481](cont'd)

ITEM 10. Amend subrule 64.4(6) as follows:

64.4(6) The facility shall have in effect a transfer agreement with one or more hospitals sufficiently close to the facility to make feasible the transfer between them of residents and their records. (III) Any facility which does not have such an agreement in effect but has attempted in good faith to enter into such an agreement with a hospital shall be considered to have such an agreement so long as it is in the public interest and essential to ensuring intermediate care facility for the ~~mentally-retarded~~ intellectually disabled services for eligible persons in the community.

ITEM 11. Amend rule 481—64.5(135C) as follows:

481—64.5(135C) Notifications required by the department. The department shall be notified:

64.5(1) Within 48 hours, by letter, any reduction or loss of direct care professional or dietary staff lasting more than seven days which places the staffing ratio of the intermediate care facility for the ~~mentally-retarded~~ intellectually disabled below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

64.5(2) Of any proposed change in the intermediate care facility for the ~~mentally-retarded's~~ intellectually disabled's functional operation or addition or deletion of required services; (III)

64.5(3) Thirty days before addition, alteration, or new construction is begun in the intermediate care facility for the ~~mentally-retarded~~ intellectually disabled, or on the premises; (III)

64.5(4) Thirty days in advance of closure of the intermediate care facility for the ~~mentally-retarded~~ intellectually disabled; (III)

64.5(5) Within two weeks of any change in administrator; (III)

64.5(6) When any change in the category of license is sought; (III)

64.5(7) Prior to the purchase, transfer, assignment, or lease of an intermediate care facility for the ~~mentally-retarded~~ intellectually disabled, the licensee shall:

- a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)
- b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)
- c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's intermediate care facility for the ~~mentally-retarded~~ intellectually disabled to the named prospective purchaser, transferee, assignee, or lessee. (III)

64.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of an intermediate care facility for the ~~mentally-retarded~~ intellectually disabled, the department shall, upon request, send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

ITEM 12. Amend rule 481—64.59(135C) as follows:

481—64.59(135C) County care facilities. In addition to Chapter 64 licensing rules, county care facilities licensed as intermediate care facilities for the ~~mentally-retarded~~ intellectually disabled must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

ARC 0598C**IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495]****Notice of Intended Action**

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 97B.4 and 97B.15, the Iowa Public Employees' Retirement System (IPERS) hereby gives Notice of Intended Action to amend Chapter 4, “Employers,” Chapter 5, “Employees,” Chapter 11, “Application for, Modification of, and Termination of Benefits,” Chapter 12, “Calculation of Monthly Retirement Benefits,” Chapter 13, “Disability for Regular and Special Service Members,” Chapter 15, “Dividends,” and Chapter 16, “Domestic Relations Orders and Other Assignments,” Iowa Administrative Code.

IPERS proposes the following amendments to implement new contribution rates for regular and special service members beginning July 1, 2013; to clarify when IPERS coverage ends for employees who are employed in two IPERS covered positions at the same time; to correct a date in a subrule regarding bona fide retirement of licensed health care professionals as amended in 2012 Iowa Acts, House File 2465, section 21; to implement prior legislative changes in 2010 Iowa Acts, House File 2518, section 19, clarifying the IPERS benefit calculation for members vested by age and not service, and for members aged 70 and older receiving an in-service benefit; to correct an error in terminology in a subrule regarding fast-track review of a disability application; to clarify the time frame in which to review disability applicant files; to establish rules for payments to members and beneficiaries of the favorable experience dividend (FED) account balance when the account balance is not sufficiently funded; and to update several rules regarding IPERS' administration of domestic relations orders.

These amendments were prepared after consultation with IPERS' staff, IPERS' actuary and the Benefits Advisory Committee.

Any interested person may make written suggestions or comments on the proposed amendments on or before February 26, 2013. Such written suggestions or comments should be directed to the IPERS Administrative Rules Coordinator at IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. Persons who wish to present their comments orally may contact the IPERS Administrative Rules Coordinator at (515)281-3081. Comments may also be submitted by fax to (515)281-0045 or by e-mail to adminrule@ipers.org.

Also, a public hearing will be held on February 26, 2013, at 9 a.m. at IPERS, 7401 Register Drive, Des Moines, Iowa. Persons may present their views either orally or in writing. At the hearing persons will be asked to give their names and addresses for the record and to confine their remarks to the subject matter of the amendments.

There are no waiver provisions included in the proposed amendments.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 97B.4 and 97B.15.

The following amendments are proposed.

ITEM 1. Amend paragraph **4.6(1)“b”** as follows:

b. Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495](cont'd)

	Effective July 1, 2012	Effective July 1, 2013
Combined rate	14.45%	<u>14.88%</u>
Employer	8.67%	<u>8.93%</u>
Employee	5.78%	<u>5.95%</u>

ITEM 2. Amend subrule 4.6(2) as follows:

4.6(2) Contribution rates for sheriffs and deputy sheriffs are as follows.

	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011	Effective July 1, 2012	Effective July 1, 2013
Combined rate	15.04%	15.24%	17.88%	19.66%	19.80%	<u>19.76%</u>
Employer	7.52%	7.62%	8.94%	9.83%	9.90%	<u>9.88%</u>
Employee	7.52%	7.62%	8.94%	9.83%	9.90%	<u>9.88%</u>

ITEM 3. Amend subrule 4.6(3) as follows:

4.6(3) Contribution rates for protection ~~occupation~~ occupations are as follows.

	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011	Effective July 1, 2012	Effective July 1, 2013
Combined rate	14.08%	15.34%	16.59%	16.62%	17.11%	<u>16.90%</u>
Employer	8.45%	9.20%	9.95%	9.97%	10.27%	<u>10.14%</u>
Employee	5.63%	6.14%	6.64%	6.65%	6.84%	<u>6.76%</u>

ITEM 4. Amend subrule 5.2(33) as follows:

5.2(33) ~~School employees~~ Employees who work in additional positions with additional duties, along with normal duties with the same employer, shall be considered covered employees until all of their compensated duties to their employer cease. (Examples include teacher/coach; teacher/summer driver's education instructor; and ~~Phase I, II, and III employment~~ city employee/paid firefighter.)

ITEM 5. Amend subrule 11.5(2), introductory paragraph, as follows:

11.5(2) *Bona fide retirement—licensed health care professionals.* For retirees whose first month of entitlement is no earlier than July 2004 and no later than June ~~2012~~ 2014, a retiree who is reemployed as a "licensed health care professional" by a "public hospital" does not have a bona fide retirement until all employment with covered employers is terminated for at least one calendar month. In order to receive retirement benefits, the member must file a completed application for benefits form before returning to any employment with a covered employer.

ITEM 6. Amend subrule 12.5(1) as follows:

12.5(1) For each member who is vested prior to July 1, 2012, ~~but~~ and is retiring prior to July 1, 2012, with less than four complete years of service, a monthly annuity shall be determined by applying the total reserve as of the effective retirement date (plus any retirement dividends standing to the member's credit on December 31, 1966) to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable). If the member's retirement occurs before January 1, 1995, IPERS' revised 6.5 percent tables shall be used. If the member's retirement occurs after December 31, 1994, IPERS' 6.75 percent tables shall be used.

ITEM 7. Amend subrule 12.5(7) as follows:

12.5(7) For members ~~who first become vested~~ retiring after June 30, 2012, the money purchase benefit calculated pursuant to this rule shall be provided to members who are not vested by service as defined in Iowa Code section 97B.1A(25)"d."

IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495](cont'd)

ITEM 8. Amend rule 495—12.6(97B) as follows:

495—12.6(97B) Recalculation for a member aged 70. A member remaining in covered employment after attaining the age of 70 years may receive a retirement allowance without terminating the covered employment. A member who is in covered employment, attains the age of 70 and begins receiving a retirement allowance must terminate all covered employment before the member's retirement allowance can be recalculated to take into account service after the member's original FME. The termination of employment must be a true severance lasting at least 30 days. The formula to be used in recalculating such a member's retirement allowance depends on the date of the member's FME and the member's termination date, as follows:

If the member is receiving a retirement allowance with an FME prior to July 1, 2000, and terminates covered employment on or after January 1, 2000, the member's retirement formula for recalculation purposes shall be the formula in effect at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation.

In all other cases, the recalculation for a member aged 70 who retires while actively employed shall use the retirement formula in effect at the time of the member's FME.

Payments under this rule shall begin no earlier than the month following the month of termination, upon IPERS' receipt of a member's application for recalculation.

A member receiving a recalculation under this rule after June 30, 2012, will have the member's average covered wage calculated as follows. IPERS will calculate the average high three covered wage as of June 30, 2012. IPERS will next calculate the average high five covered wage at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation. IPERS will determine the benefit amount based on the calculation that produces the greatest benefit to the member.

ITEM 9. Amend subrule 13.2(6) as follows:

13.2(6) Fast-track review. IPERS' disability retirement benefits officer may refer any case to IPERS' chief benefits officer (CBO) for fast-track review. The ~~CEO~~ CBO or the ~~CEO's~~ CBO's designee may, based upon a review of the member's application and medical records, determine that the medical board be permitted to make its recommendations based solely upon a review of the application and medical records, without requiring the member to submit to additional medical examinations by, or coordinated through, the medical board.

ITEM 10. Amend subrule 13.2(7) as follows:

13.2(7) Initial administrative determination. The medical board's letter of recommendation, test results, and supporting notes, and the member's file shall be forwarded to IPERS. Except as otherwise requested by IPERS, the medical board shall forward hospital discharge summary reports rather than the entire set of hospital records. The complete file shall be reviewed by the system's disability retirement benefits officer, who shall, in consultation with the system's legal counsel, make the initial disability determination. Written notification of the initial disability determination shall be sent to the member and the member's employer within 14 business days after a complete file has been returned to IPERS for the initial disability determination.

ITEM 11. Adopt the following **new** subrules 15.2(6) and 15.2(7):

15.2(6) Determination of sufficiency of FED reserve account. The system is charged in Iowa Code section 97B.49F(2) "d" with determining whether the reserve account is sufficiently funded to make a distribution. The system shall make this determination in the following manner.

a. The system shall declare the value of the FED reserve account balance as specified in the Allocation of Net Assets Held in Trust in the financial statements for the fiscal year that ended immediately preceding a January FED payment. The value shall include, but is not limited to, investment income and expenses and certain noninvestment income that are properly recorded for the FED reserve balance based on standard accounting rules used to determine a final balance at the conclusion of a fiscal year.

IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495](cont'd)

b. The above-declared reserve account balance shall be compared to the total estimated FED payment for the following January as calculated pursuant to rule 495—15.2(97B) utilizing a 1 percent multiplier.

c. The reserve account shall be declared not sufficiently funded when the estimated FED payment as determined in paragraph “*b*” of this subrule is equal to or greater than the declared reserve account balance as defined in paragraph “*a*” of this subrule.

15.2(7) *Determination of FED distribution if reserve account is not sufficiently funded.*

a. When the system has determined pursuant to subrule 15.2(6) that the reserve account is not sufficiently funded, the system shall declare a multiplier to be used in the formula pursuant to rule 495—15.2(97B) that is best estimated to approximate a full distribution of the declared reserve account balance as of the preceding June 30 fiscal year end.

b. No investment gains or losses shall change this balance between July 1 and the FED payment in January of the fiscal year in which the remaining balance of the reserve account will be paid by IPERS.

c. Any remaining reserve account balance shall be credited among the membership groups in the net assets held in trust, and the reserve account balance will be zero at the end of the fiscal year in which a FED payment is made pursuant to this subrule.

d. Any funds the system collects from a FED payment to a member or beneficiary because of an erroneous FED payment made by IPERS shall be deposited in the IPERS trust fund.

e. Payments under this subrule will represent a final distribution of the balance of the reserve account as determined in rule 495—15.2(97B) effectively halting any future FED payment, unless and until the reserve account is funded again pursuant to subrule 15.2(1).

f. No claim or administrative appeal will be allowed under this subrule if made more than 30 calendar days following the date on which IPERS made a FED payment to a member or beneficiary based upon the date of the EFT or the date IPERS mailed a state warrant to the member or beneficiary.

g. No payment will occur after January 31 in the year of the FED payment under this subrule for any adjustment to any previous fiscal years' FED payment to a member or beneficiary.

ITEM 12. Amend paragraph **16.2(3)“a”** as follows:

a. IPERS uses the shared payment method for payments under a domestic relations order. IPERS will not create a separate account for the alternate payee. Payment to the alternate payee shall be in a lump sum if the member's benefits are paid in a lump sum distribution or as monthly payments if the member's benefits are paid under a retirement option. A member shall not be able to receive an actuarial equivalent (AE) under Iowa Code section 97B.48(1) unless the total benefit payable with respect to that member meets the applicable requirements. All divisions of benefits shall be based on the gross amount of monthly or lump sum benefits payable. Federal and state income taxes shall be deducted from the member's and alternate payee's respective shares and reported under their respective federal tax identification numbers. Unrecovered basis shall be allocated on a pro rata basis to the member and alternate payee.

ITEM 13. Amend paragraph **16.2(3)“c”** as follows:

c. If a QDRO or an ADRO directs the member to name the alternate payee under the order as a designated beneficiary, and the member fails to do so, the provisions of the QDRO or ADRO awarding the alternate payee a share of the member's death benefit shall be deemed, except as revoked or modified in a subsequent QDRO or ADRO, to operate as a beneficiary designation, and shall be given first priority by IPERS in the determination and payment of such member's death benefits. Death benefits remaining after payments required by the QDRO or ADRO, to the extent possible, shall then be made according to the terms of the member's most recent beneficiary designation. If a QDRO or an ADRO does not require the member to select an option, the member is allowed to select any option at retirement.

ITEM 14. Amend paragraph **16.2(3)“g”** as follows:

g. A person who attempts to make IPERS a party or requires IPERS to appear as a witness to a domestic relations action in order to determine an alternate payee's right to receive a portion of the benefits payable to a member shall be liable to IPERS for its costs and attorney's fees.

IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495](cont'd)

ITEM 15. Amend paragraph **16.2(3)“k”** as follows:

k. If a QDRO or an ADRO requires the member to select an option with joint and survivor provisions (Option 4 or 6) and name the alternate payee as contingent annuitant, ~~acceptable~~ the order must state the percentage in Option 4 or 6 to be payable to the alternate payee as contingent annuitant (the currently available percentages under Option 4 or 6 are 25, 50, 75 and 100 percent). ~~Acceptable~~ birth proof for the alternate payee as the named contingent annuitant, pursuant to 495—subrule 11.1(2), shall ~~must~~ also be provided to IPERS prior to approval of the order being approved by IPERS.

ARC 0587C

LABOR SERVICES DIVISION[875]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 88.5, the Labor Commissioner hereby gives Notice of Intended Action to amend Chapter 10, “General Industry Safety and Health Rules,” and Chapter 26, “Construction Safety and Health Rules,” Iowa Administrative Code.

The proposed amendments adopt by reference changes to federal occupational safety and health standards. The changes to the federal standards make corrections and technical amendments to the general industry and construction standards. The federal Occupational Safety and Health Administration determined that these changes were not subject to the procedures for public notice and comment found in federal law because no stakeholder is likely to object and the changes do not impact existing rights or duties.

The changes remove the noun “fits” from Appendix C of the respiratory protection standard; correct erroneous cross references appearing in Appendix A of the scaffold standard; restore reporting requirements removed in error from the mechanical power press standard; remove outdated references from the construction sling standard; and update references to the American National Standards Institute head protection standard.

The principal reasons for adoption of these amendments are to implement legislative intent, protect the safety and health of Iowa workers, and make Iowa’s regulations current and consistent with federal regulations. Pursuant to Iowa Code subsection 88.5(1) and 29 CFR 1953.5, Iowa must adopt changes to the federal occupational safety and health standards.

If requested in accordance with Iowa Code section 17A.4(1)“b” by the close of business on March 12, 2013, a public hearing will be held on March 13, 2013, at 10 a.m. in the Capitol View Room at 1000 East Grand Avenue, Des Moines, Iowa. Interested persons will be given the opportunity to make oral statements and file documents concerning the proposed amendments. The facility for the oral presentations is accessible to and functional for persons with physical disabilities. Persons who have special requirements should call (515)281-5915 in advance to arrange access or other needed services.

Written data, views, or arguments to be considered in adoption shall be submitted by interested persons no later than March 13, 2013, to Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa 50319-0209. Comments may be sent electronically to kathleen.uehling@iwd.iowa.gov.

No variance procedures are included in this rule. Variances procedures are set forth in 875—Chapter 5.

After analysis and review of this rule making, jobs could be impacted. However, these amendments are implementing federally mandated regulations, and the State of Iowa is only implementing the federal regulations. The requirements imposed on Iowa businesses by these regulations do not exceed those imposed by federal law.

These amendments are intended to implement Iowa Code section 88.5 and 29 CFR 1953.5.

LABOR SERVICES DIVISION[875](cont'd)

The following amendments are proposed.

ITEM 1. Amend rule **875—10.20(88)** by inserting the following at the end thereof:

77 Fed. Reg. 37598 (June 22, 2012)

77 Fed. Reg. 46949 (August 7, 2012)

ITEM 2. Amend rule **875—26.1(88)** by inserting the following at the end thereof:

77 Fed. Reg. 23118 (April 18, 2012)

77 Fed. Reg. 37598 (June 22, 2012)

77 Fed. Reg. 42988 (July 23, 2012)

77 Fed. Reg. 46949 (August 7, 2012)

ARC 0597C

LABOR SERVICES DIVISION[875]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)“b.”

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 89A.3, the Elevator Safety Board hereby gives Notice of Intended Action to amend Chapter 71, “Administration of the Conveyance Safety Program,” Iowa Administrative Code.

These amendments remove obsolete language regarding construction personnel hoists and rescind a rule pertaining to the modernization of certain elevators. The modernization rule requires that if a project would replace more than 50 percent of an elevator, the entire elevator must be brought into compliance with current codes. The fee for alteration permits is now tied to the 50-percent rule. The changes rescind the 50-percent rule, substitute a flat fee for alteration permits, and make conforming amendments.

The purposes of these amendments are to protect the health and safety of the public and implement legislative intent.

If requested in accordance with Iowa Code section 17A.4(1)“b” by the close of business on March 6, 2013, a public hearing will be held on March 7, 2013, at 10 a.m. in the Capitol View Room at 1000 East Grand Avenue, Des Moines, Iowa. Interested persons will be given the opportunity to make oral statements and file documents concerning the proposed amendments. The facility for the oral presentations is accessible to and functional for persons with physical disabilities. Persons who have special requirements should call (515)281-5915 in advance to arrange access or other needed services.

Written data, views, or arguments to be considered in adoption shall be submitted by interested persons no later than March 7, 2013, to Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa 50319-0209. Comments may be sent electronically to kathleen.uehling@jwd.iowa.gov.

No variance procedures are included in this rule. Applicable variance procedures are set forth in 875—Chapter 66.

After analysis and review of this rule making, these amendments could have a positive impact on jobs. This rule making is a common-sense approach that promotes safety and removes unnecessary, burdensome regulation on small businesses. Small businesses and building owners who want to update their elevators now have an incentive to update and modernize their elevators to the greatest potential without being subject to overregulation. The current rule creates a disincentive for businesses to update their elevators more than 50 percent. Now building owners can update their elevators as much as they want, which will be both an incentive to Iowa businesses and a safety benefit to Iowans.

These amendments are intended to implement Iowa Code chapter 89A.

The following amendments are proposed.

LABOR SERVICES DIVISION[875](cont'd)

ITEM 1. Rescind the definition of “Major alteration” in rule ~~875—71.1(89A)~~.

ITEM 2. Amend subrule 71.7(5) as follows:

~~71.7(5)~~ An operating permit is automatically suspended when ~~construction is initiated to alter less than or equal to 50 percent of an elevator as calculated pursuant to rule 875—71.9(89A)~~ an alteration begins. The operating permit automatically resumes when the elevator passes an inspection pursuant to rule 875—71.11(89A).

ITEM 3. Rescind subrule ~~71.7(6)~~.

ITEM 4. Renumber subrules ~~71.7(7)~~ and ~~71.7(8)~~ as ~~71.7(6)~~ and ~~71.7(7)~~.

ITEM 5. Amend subrule 71.9(5) as follows:

~~71.9(5)~~ If a complete installation permit application was submitted for a CPH pursuant to subrule 71.5(3), at least seven days’ advance notice of each CPH jump shall be provided to the labor commissioner. ~~For a CPH installed without an installation permit prior to July 1, 2008, a completed alteration permit application shall be submitted to the labor commissioner at least seven days before each CPH jump.~~

ITEM 6. Rescind rule 875—71.10(89A) and adopt the following new rule in lieu thereof:

875—71.10(89A) Alterations.

71.10(1) Alterations or changes shall comply with rule 875—72.13(89A) or rule 875—73.8(89A), as applicable.

71.10(2) A conveyance that is relocated shall be brought into compliance with all codes that are applicable at the time of relocation.

71.10(3) With the exception of replacing brushes on or adding brushes to escalators, all alterations of conveyances other than elevators shall require that the entire conveyance be brought into compliance with the current code.

ITEM 7. Amend subrule 71.11(1) as follows:

71.11(1) Scope of inspections.

a. Comprehensive. Periodic inspections shall be comprehensive. ~~Conveyances subjected to major alterations, elevators~~ Elevators being transferred from construction permits to operating permits, previously dormant conveyances being returned to service, relocated conveyances, and new conveyances shall be inspected in their entirety prior to operation.

b. Limited. The scope of an inspection after an alteration ~~other than a major alteration~~ shall be determined by rule 875—72.13(89A) or 875—73.8(89A), as applicable. However, if the inspector notices a safety hazard in plain view outside the altered components, or if the periodic inspection is due, the entire conveyance shall be inspected.

ITEM 8. Rescind subrule 71.16(4) and adopt the following new subrule in lieu thereof:

71.16(4) Alteration permits.

a. The fee for an elevator alteration permit shall be \$500 and shall cover the initial print review, alteration permit, and initial inspection.

b. The fee for each CPH extension shall be \$150. The total fee required for all planned CPH extensions shall be submitted with the installation permit application pursuant to subrule 71.5(3).

c. For all conveyances other than elevators, the fees for new installations shall apply to alterations.

TRANSPORTATION DEPARTMENT

Public Notice

Iowa Code section 17A.7(2) requires each state agency to conduct an ongoing and comprehensive review of all of the agency’s rules. The Department invites interested persons to participate in the review of its rules.

TRANSPORTATION DEPARTMENT(cont'd)

Any person who wishes to participate shall submit a written request on or before March 6, 2013, to Tracy George, Administrative Rules Coordinator, Office of Policy and Legislative Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; fax (515)817-6511; e-mail tracy.george@dot.iowa.gov. A request shall include the requester's name, mailing or e-mail address, and telephone number and the specific chapters of interest.

Requesters will be contacted and asked to submit comments when the rules for which they have expressed an interest are reviewed.

Following is a list of the Department's chapters that will be reviewed:

<u>Chapter No.</u>	<u>Chapter Title</u>
GENERAL	
1	Organization of the Department of Transportation
2	Provisions Applicable to All Rules
4	Public Records and Fair Information Practices
10	Administrative Rules
11	Waiver of Rules
12	Declaratory Orders
13	Contested Cases
20	Procurement of Equipment, Materials, Supplies and Services
25	Competition with Private Enterprise
27	Interest on Retained Funds
28	Iowa Transportation Map
40	Recovery of Damages to Highways or Highway Structures
HIGHWAYS	
101	Farm-to-Market Review Board
102	Secondary Road Fund Distribution Committee
105	Holiday Rest Stops
106	Promotion of Iowa Agricultural Products at Rest Areas
RIGHT-OF-WAY AND ENVIRONMENT	
110	Highway Project Planning
111	Real Property Acquisition and Relocation Assistance
112	Primary Road Access Control
115	Utility Accommodation
116	Junkyard Control
117	Outdoor Advertising
118	Logo Signing
119	Tourist-Oriented Directional Signing
120	Private Directional Signing
121	Adopt-A-Highway Program
122	Keep Iowa Beautiful Program
123	Rest Area Sponsorship Program
124	Highway Helper Sponsorship Program
CONSTRUCTION	
125	General Requirements and Covenants for Highway and Bridge Construction

TRANSPORTATION DEPARTMENT(cont'd)

TRAFFIC OPERATIONS

- 130 Signing Manual
- 131 Signing on Primary Roads
- 132 Iowa Scenic Byway Program
- 136 Lighting
- 140 Traffic Signals and Beacons on Primary Roads
- 142 Speed Zoning on Primary Highways
- 143 Traffic Signal Synchronization

PRIMARY ROAD EXTENSIONS

- 150 Improvements and Maintenance on Primary Road Extensions
- 151 City Requests for Closure of Primary Road Extensions

SPECIAL HIGHWAY PROGRAMS

- 160 County and City Bridge Construction Funds
- 161 Federal-Aid Highway Bridge Replacement and Rehabilitation Program
- 162 Bridge Safety Fund
- 163 RISE Program
- 164 Traffic Safety Improvement Program
- 165 Recreational Trails Program

LOCAL SYSTEMS

- 170 Allocation of Farm-to-Market Road Funds
- 172 Availability of Instructional Memorandums to County Engineers
- 173 Preparation of Secondary Road Construction Programs, Budgets, and County Engineers' Annual Reports
- 174 Reimbursable Services and Supplies
- 178 Project Cost Reporting Requirements for Cities and Counties
- 180 Public Improvement Quotation Process for Governmental Entities
- 181 Statewide Standard for Permitting Certain Implements of Husbandry

INTERMODAL

- 201 Intermodal Pilot Project Program

VEHICLES

- 400 Vehicle Registration and Certificate of Title
- 401 Special Registration Plates
- 405 Salvage
- 410 Special Mobile Equipment
- 411 Persons with Disabilities Parking Permits
- 415 Driver's Privacy Protection—Certificates of Title and Vehicle Registration
- 424 Transporter Plates
- 425 Motor Vehicle and Travel Trailer Dealers, Manufacturers, Distributors and Wholesalers
- 430 Motor Vehicle Leasing Licenses
- 431 Vehicle Recyclers

TRANSPORTATION DEPARTMENT(cont'd)

450	Motor Vehicle Equipment
451	Emergency Vehicle Permits
452	Reflective Devices on Slow-Moving Vehicles
454	Towing Wrecked or Disabled Vehicles
480	Abandoned Vehicles
MOTOR CARRIERS	
500	Interstate Registration and Operation of Vehicles
505	Interstate Motor Vehicle Fuel Licenses and Permits
511	Special Permits for Operation and Movement of Vehicles and Loads of Excess Size and Weight
513	Compacted Rubbish Vehicle Permits
520	Regulations Applicable to Carriers
524	For-Hire Intrastate Motor Carrier Authority
529	For-Hire Interstate Motor Carrier Authority
DRIVER LICENSES	
600	General Information
601	Application for License
602	Classes of Driver's Licenses
604	License Examination
605	License Issuance
607	Commercial Driver Licensing
610	Release of Computerized Driver's License and Nonoperator's Identification Card Records
611	Driver's Privacy Protection—Driver's License and Nonoperator's Identification Card
615	Sanctions
620	OWI and Implied Consent
625	Driver's Licenses for Undercover Law Enforcement Officers
630	Nonoperator's Identification
634	Driver Education
635	Motorcycle Rider Education (MRE)
636	Motorized Bicycle Rider Education
640	Financial Responsibility
641	Financial Liability Coverage Cards
AERONAUTICS	
700	Aeronautics Administration
710	Airport Improvement Program
715	Commercial Air Service Marketing Program
716	Commercial Air Service Vertical Infrastructure Program
717	General Aviation Airport Vertical Infrastructure Program
720	Iowa Airport Registration
750	Aircraft Registration
RAILROADS	
800	Items of General Application for Railroads

TRANSPORTATION DEPARTMENT(cont'd)

802	Reporting of Railroad Accidents/Incidents
810	Railroad Safety Standards
811	Highway-Railroad Grade Crossing Warning Devices
812	Classifications and Standards for Highway-Railroad Grade Crossings
813	Close-Clearance Warning Signs Along Railroad Tracks
820	Highway Grade Crossing Safety Fund
821	Highway-Railroad Grade Crossing Surface Repair Fund
822	Railroad Revolving Loan and Grant Fund Program
PUBLIC TRANSIT	
910	Coordination of Public Transit Services
911	School Transportation Services Provided by Regional Transit Systems
920	State Transit Assistance
921	Advanced Allocations of State Transit Assistance Funding
922	Federal Transit Assistance
923	Capital Match Revolving Loan Fund
924	Public Transit Infrastructure Grant Program

ARC 0591C**TRANSPORTATION DEPARTMENT[761]****Notice of Intended Action**

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code sections 307.10, 307.12, 321.449 and 321.450, the Department of Transportation hereby gives Notice of Intended Action to amend Chapter 520, "Regulations Applicable to Carriers," Iowa Administrative Code.

Iowa Code section 321.449 requires the Department to adopt rules consistent with the Federal Motor Carrier Safety Regulations (FMCSR) promulgated under United States Code, Title 49, and found in 49 Code of Federal Regulations (CFR), Parts 385 and 390 to 399. Iowa Code section 321.450 requires the Department to adopt rules consistent with the Federal Hazardous Materials Regulations (HMR) promulgated under United States Code, Title 49, and found in 49 CFR Parts 107, 171 to 173, 177, 178 and 180.

Commercial vehicles transporting goods in interstate commerce are subject to the FMCSR on the effective dates specified in the Federal Register (FR). Commercial vehicles transporting hazardous materials in interstate commerce or transporting certain hazardous materials intrastate are subject to the HMR on the effective dates specified in the FR. The adoption of the federal regulations by the Department will extend the enforcement of the regulations to commercial vehicles operated intrastate unless exempted by statute.

Proposed federal regulations are published in the FR to allow a period for public comment, and after adoption, the final regulations are published in the FR. Each year a revised edition of 49 CFR is published, incorporating all of the final regulations adopted during the year.

To ensure the consistency required by statute, the Department annually adopts the specified parts of 49 CFR as adopted by the United States Department of Transportation.

The amendments to the FMCSR and the HMR that have become final and effective since the 2011 edition of the CFR are listed below. The parts affected are followed by FR citations.

TRANSPORTATION DEPARTMENT[761](cont'd)

Amendments to the FMCSR and Federal HMRPart 391 (FR Vol. 76, No. 220, Pages 70661-70663, 11-15-11)

The Federal Motor Carrier Safety Administration (FMCSA) amends its regulations to keep in effect until January 30, 2014, the requirement that interstate drivers subject to the commercial driver's license (CDL) regulations and the federal physical qualification requirements must retain paper copies of the drivers' medical examiner's certificates. Interstate motor carriers are also required to retain copies of the drivers' medical certificates in the drivers' qualification files. This action is being taken to ensure the medical qualification of CDL holders until all states are able to post the medical self-certification and medical examiner's certificate data on the Commercial Driver's License Information System (CDLIS) driver record. This rule does not, however, extend the compliance dates for states to collect and to post to the CDLIS driver record data from a CDL holder's medical self-certification and medical examiner's certificate. Effective Date: December 15, 2011.

Parts 177, 390, 391 and 392 (FR Vol. 76, No. 232, Pages 75470-75488, 12-2-11)

The FMCSA and Pipeline Hazardous Materials Safety Administration (PHMSA) are amending the FMCSRs and the HMRs to restrict the use of hand-held mobile telephones by drivers of commercial motor vehicles (CMVs). This rule making will improve safety on the nation's highways by reducing the prevalence of distracted driving-related crashes, fatalities, and injuries involving drivers of CMVs. The FMCSA and PHMSA also amend regulations to implement new driver disqualification sanctions for drivers of CMVs who fail to comply with this federal restriction and new driver disqualification sanctions for commercial driver's license (CDL) holders who have multiple convictions for violating a state or local law or ordinance on motor vehicle traffic control that restricts the use of hand-held mobile telephones. Additionally, motor carriers are prohibited from requiring or allowing drivers of CMVs to use hand-held mobile telephones. Effective Date: January 3, 2012.

Parts 385, 390 and 395 (FR Vol. 76, No. 248, Pages 81133-81188, 12-27-11)

The FMCSA revises the hours of service regulations to limit the use of the 34-hour restart provision to once every 168 hours and to require that anyone using the 34-hour restart provision have as part of the restart two periods that include 1 a.m. to 5 a.m. The rule also includes a provision that allows truckers to drive if the driver had a break of at least 30 minutes, at a time of the driver's choosing, sometime within the previous 8 hours. This rule does not include a change to the daily driving limit because the FMCSA is unable to definitively demonstrate that a 10-hour limit—which it favored in the notice of proposed rule making—would have higher net benefits than an 11-hour limit. The current 11-hour limit is therefore unchanged at this time. The 60- and 70-hour limits are also unchanged. The purpose of the rule is to limit the ability of drivers to work the maximum number of hours currently allowed, or close to the maximum, on a continuing basis to reduce the possibility of driver fatigue. Long daily and weekly hours are associated with an increased risk of crashes and with the chronic health conditions associated with lack of sleep. These changes will affect only the small minority of drivers who regularly work the longer hours. Effective Date: February 27, 2012.

Parts 172 and 173 (FR Vol. 76, No. 249, Pages 81396-81400, 12-28-11)

On July 20, 2011, the PHMSA published a final rule under Docket Number PHMSA-2009-0151 (HM-218F) making miscellaneous amendments to HMR; 49 CFR Parts 171-180. The amendments made by PHMSA in the July 20, 2011, final rule promote safer transportation practices; eliminate unnecessary regulatory requirements; finalize outstanding petitions for rule making; facilitate international commerce; and simplify the regulations. This final rule corrects errors in the pictorial display of labels, eliminates references to transitional provisions that were previously removed from the HMR, clarifies shipping paper amendments, corrects an editorial error, and extends the effective date of certain shipping paper amendments adopted in the July 20, 2011, final rule. Effective Date: December 28, 2011.

TRANSPORTATION DEPARTMENT[761](cont'd)

Part 390 (FR Vol. 76, No. 251, Pages 82179-82180, 12-30-11)

The FMCSA is correcting a final rule that appeared in the FR on December 2, 2011 (76 FR 75470), which restricted the use of hand-held mobile telephones by drivers of CMVs. That rule was jointly issued by FMCSA and PHMSA, but this correction only affects an FMCSA regulation. Effective Date: January 3, 2012.

Parts 172 and 173 (FR Vol. 76, No. 251, Pages 82163-82179, 12-30-11)

This PHMSA document responds to administrative appeals, provides clarifications, and corrects typographical and other minor errors adopted in an international harmonization final rule published January 19, 2011 (HM-215K; 76 FR 3308). The final rule amended the HMRs by revising, removing or adding proper shipping names, the hazard class of a material, packing group assignments, special provisions, packaging authorizations, packaging sections, air transport quantity limitations, and vessel stowage requirements. The amendments were necessary to align the HMR with recent revisions to international standards for the transport of hazardous materials by all modes. Effective Date: January 1, 2012.

Part 391 (FR Vol. 77, No. 8, Pages 1889-1891, 01-12-12)

The FMCSA amends its December 3, 2011, final rule that restricted the use of hand-held mobile telephones by drivers of CMVs. That rule was jointly issued by FMCSA and PHMSA, but this technical amendment only affects an FMCSA regulation. The purpose of this rule is to correct a clerical error. Effective Date: January 12, 2012.

Part 391 (FR Vol. 77, No. 19, Pages 4479-4491, 01-30-12)

The FMCSA amends the physical qualifications for drivers and the instructions for the medical examination report to clarify that drivers may not use Schedule I drugs and be qualified to drive CMVs under any circumstances. The rule harmonizes FMCSA's provisions regarding pre-employment and return-to-duty test refusals with corresponding U.S. Department of Transportation-wide provisions. The rule also corrects inaccurate uses of the term "actual knowledge." Effective Date: February 29, 2012.

Part 395 (FR Vol. 77, No. 29, Page 7544, 02-13-12)

The FMCSA corrects the hours of service final rule published on December 27, 2011 (76 FR 81143). This notice corrects the amendatory language or guidance to legal editors of the CFR on the proper codification of the December 27, 2011, rule. This notice does not change, in any manner, the regulatory text. Effective Date: February 27, 2012.

Part 391 (FR Vol. 77, No. 35, Pages 10391-10400, 02-22-12)

The FMCSA is correcting a final rule that appeared in the FR on January 30, 2012 (77 FR 4479), which amended the physical qualifications for drivers and the instructions for the medical examination report to clarify that drivers may not use Schedule I drugs and be qualified to drive CMVs under any circumstances. Effective Date: February 22, 2012.

Parts 390 and 391 (FR Vol. 77, No. 77, Pages 24103-24135, 04-20-12)

The FMCSA establishes a National Registry of Certified Medical Examiners (National Registry) with requirements that all medical examiners who conduct physical examinations for interstate CMV drivers meet the following criteria: complete certain training concerning FMCSA's physical qualification standards, pass a test to verify an understanding of those standards, and maintain and demonstrate competence through periodic training and testing. Following establishment of the National Registry and a transition period, FMCSA will require that motor carriers and drivers use only those medical examiners on the FMCSA's National Registry and will only accept as valid medical examiner's certificates issued by medical examiners listed on the National Registry. FMCSA is developing the National Registry program to improve highway safety and driver health by requiring that medical examiners be trained and certified so they can determine effectively whether a CMV driver's medical

TRANSPORTATION DEPARTMENT[761](cont'd)

fitness for duty meets FMCSA's standards. Effective Date: May 21, 2012. Compliance required: May 21, 2014.

Part 385 (FR Vol. 77, No. 89, Pages 26989-26990, 05-08-12)

The FMCSA published a final rule in the FR on Monday, May 9, 2011, that became effective on July 8, 2011. That final rule amended the CDL knowledge and skills testing standards and established new minimum federal standards for states to issue the commercial learner's permit. Since the final rule was published, FMCSA identified minor discrepancies regarding section references in existing regulatory text resulting from the final rule. This document corrects those section references. Effective Date: May 8, 2012.

Parts 385, 395 and 396 (FR Vol. 77, No. 93, Pages 28447-28451, 05-14-12)

This FMCSA final rule rescinds the final rule published on April 5, 2010, entitled "Electronic On-Board Recorders for Hours-of-Service Compliance" and amended by a September 13, 2010, technical amendment. This action responds to a decision of the Court of Appeals for the Seventh Circuit that vacated the April 2010 final rule. Effective Date: May 14, 2012.

Parts 385 and 395 (FR Vol. 77, No. 93, Pages 28451-28454, 05-14-12)

This FMCSA final rule repromulgates in the CFR a statutory requirement that FMCSA revoke the operating authority registration of a for-hire motor carrier for failure to comply with safety fitness requirements. If the FMCSA determines that a motor carrier is "unfit" based on its safety fitness determination procedures, the FMCSA must revoke the carrier's operating authority registration. Unfit motor carriers are prohibited from operating in interstate commerce, and the Secretary of Transportation is required by statute to revoke the motor carrier's operating authority registration. This final rule also repromulgates several technical provisions and makes nonsubstantive administrative changes. These changes, initially adopted as part of the April 5, 2010, final rule entitled "Electronic On-Board Recorders for Hours-of-Service Compliance," are necessary because, for reasons unrelated to this final rule, the United States Court of Appeals for the Seventh Circuit invalidated the previous rule. Effective Date: May 14, 2012.

Parts 390 and 396 (FR Vol. 77, No. 113, Pages 34846-34853, 06-12-12)

The FMCSA eliminates the requirement for drivers operating intermodal equipment to submit and intermodal equipment providers to retain driver-vehicle inspection reports when the driver has neither found nor been made aware of any defects in the intermodal equipment. This rule responds to a joint petition for rule making from the Ocean Carrier Equipment Management Association and the Institute of International Container Lessors. Effective Date: June 12, 2012.

Parts 171, 172, 173 and 180 (FR Vol. 77, No. 122, Pages 37961-37992, 06-25-12)

The PHMSA is amending the HMRs to incorporate provisions contained in certain widely used or longstanding rail special permits that have general applicability and established safety records. Special permits allow a company or an individual to package or ship a hazardous material in a manner that varies from the regulations, provided an equivalent level of safety is maintained. Incorporating the special permits discussed in this rule making will provide users of the regulations with wider access to the regulatory flexibility offered in these special permits, eliminate the need for numerous renewal requests, reduce paperwork burdens, and facilitate commerce while maintaining an appropriate level of safety. This rule making also responds to two petitions for rule making concerning the use of electronic shipping papers and the removal of the Association of American Railroad's AAR-600 portable tank program for previously adopted standards that meet or exceed the AAR-600 requirements. Effective Date: July 25, 2012.

Part 393 (FR Vol. 77, No. 151, Pages 46633-46640, 08-06-12)

The FMCSA amends the requirements regarding brake readjustment limits in the FMCSRs. This rule amends the readjustment limits, clarifies the application, and corrects an error in cross-referencing

TRANSPORTATION DEPARTMENT[761](cont'd)

a federal motor vehicle safety standard. This rule responds to a petition for rule making from the Commercial Vehicle Safety Alliance. Effective Date: September 5, 2012.

Various portions of the federal regulations and Iowa statutes allow some exceptions when the exceptions will not adversely impact the safe transportation of commodities on the nation's highways. Granting additional exceptions for drivers and the motor carrier industry in Iowa would adversely impact the safety of the traveling public in Iowa.

Any person or agency may submit written comments concerning these proposed amendments or may submit a written request to make an oral presentation. The comments or request shall:

1. Include the name, address, and telephone number of the person or agency authoring the comments or request.
2. Reference the number and title of the proposed rule, as given in this Notice, that is the subject of the comments or request.
3. Indicate the general content of a requested oral presentation.
4. Be addressed to the Department of Transportation, Office of Policy and Legislative Services, 800 Lincoln Way, Ames, Iowa 50010; fax (515)239-1639; Internet e-mail address: tracy.george@dot.iowa.gov.

5. Be received by the Office of Policy and Legislative Services no later than February 26, 2013.

A meeting to hear requested oral presentations is scheduled for Thursday, February 28, 2013, at 10 a.m. at the Iowa Department of Transportation's Motor Vehicle Division offices located at 6310 SE Convenience Boulevard, Ankeny, Iowa.

The meeting will be canceled without further notice if no oral presentation is requested.

The proposed amendments may have an impact on small business. A request for a regulatory analysis pursuant to Iowa Code section 17A.4A must be submitted to the Office of Policy and Legislative Services at the address listed in this Notice by March 11, 2013.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 321.449 and 321.450.

Proposed rule-making actions:

ITEM 1. Amend paragraph **520.1(1)“a”** as follows:

a. Motor carrier safety regulations. The Iowa department of transportation adopts the Federal Motor Carrier Safety Regulations, 49 CFR Parts 385 and 390-399 (October 1, ~~2011~~ 2012).

ITEM 2. Amend paragraph **520.1(1)“b”** as follows:

b. Hazardous materials regulations. The Iowa department of transportation adopts the Federal Hazardous Materials Regulations, 49 CFR Parts 107, 171-173, 177, 178, and 180 (October 1, ~~2011~~ 2012).

USURY

In accordance with the provisions of Iowa Code section 535.2, subsection 3, paragraph “a,” the Superintendent of Banking has determined that the maximum lawful rate of interest shall be:

February 1, 2012 — February 29, 2012	4.00%
March 1, 2012 — March 31, 2012	4.00%
April 1, 2012 — April 30, 2012	4.00%
May 1, 2012 — May 31, 2012	4.25%
June 1, 2012 — June 30, 2012	4.00%
July 1, 2012 — July 31, 2012	3.75%
August 1, 2012 — August 31, 2012	3.50%

USURY(cont'd)

September 1, 2012 — September 30, 2012	3.50%
October 1, 2012 — October 31, 2012	3.75%
November 1, 2012 — November 30, 2012	3.75%
December 1, 2012 — December 31, 2012	3.75%
January 1, 2013 — January 31, 2013	3.75%
February 1, 2013 — February 28, 2013	3.75%

ARC 0593C

AGRICULTURAL DEVELOPMENT AUTHORITY[25]

Adopted and Filed Emergency After Notice

Pursuant to the authority of Iowa Code sections 175.2(2) and 175.6(14), the Agricultural Development Authority amends Chapter 2, "Beginning Farmer Loan Program," and Chapter 6, "Beginning Farmer Tax Credit Program," Iowa Administrative Code.

The amendments amend the definitions for "eligible applicant" and provide for an annual recalculation of the maximum allowable net worth for the Beginning Farmer Loan Program and the Beginning Farmer Tax Credit Program.

Notice of Intended Action on these amendments was published in the Iowa Administrative Bulletin on December 12, 2012, as **ARC 0515C**. No comments were received from the public. These amendments are identical to the amendments published under Notice.

Pursuant to Iowa Code section 17A.5(2)"b"(2), the Authority finds that the normal effective date of these amendments, 35 days after publication, should be waived and the amendments made effective January 16, 2013, as they confer a benefit upon the public by allowing more individuals to qualify and allowing quicker compliance with the legislative mandate in Iowa Code section 175.2(1)"m"(1).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 175.12.

These amendments became effective January 16, 2013.

The following amendments are adopted.

ITEM 1. Amend rule **25—2.1(175)**, definition of "Eligible applicant," as follows:

"Eligible applicant" means an individual who is has a net worth of not more than the maximum allowable net worth for calendar year 2013 of \$691,172. The maximum allowable net worth for each calendar year shall be increased or decreased as of January 1 of such calendar year by an amount equal to the percentage increase or decrease (September to September) in the United States Department of Agriculture "Index of Prices Paid for Commodities and Services, Interest, Taxes, and Farm Wage Rates" reported as of October 1 of the immediately preceding calendar year. The applicant must also be a beginning farmer, as defined in Iowa Code section 175.12, who satisfies all of the criteria contained in the Act and provisions of these rules relating to recipient eligibility and who operates or will operate a farm.

ITEM 2. Amend rule **25—6.1(175)**, definition of "Eligible applicant," as follows:

"Eligible applicant" means an individual who has a net worth of less not more than \$343,000 the maximum allowable net worth for calendar year 2013 of \$366,324. The maximum net worth will be indexed annually based on the October 1 annual change in the United States Department of Agriculture's Prices Paid by Farmers Index. The maximum allowable net worth for each calendar year shall be increased or decreased as of January 1 of such calendar year by an amount equal to the percentage increase or decrease (September to September) in the United States Department of Agriculture "Index of Prices Paid for Commodities and Services, Interest, Taxes, and Farm Wage Rates" reported as of October 1 of the immediately preceding calendar year. The applicant must also satisfy all of the criteria contained in Iowa Code section 175.37 and provisions of these rules relating to recipient eligibility and must operate or intend to operate a farm.

ITEM 3. Amend rule **25—6.1(175)**, definition of "Taxpayer," as follows:

"Taxpayer" means a person or entity who may acquire or otherwise obtain or lease agricultural land in the state pursuant to Iowa Code chapter 9H or 9I. An individual may claim a tax credit of a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual. The amount claimed shall be based upon the pro-rata share of the individual earnings from the partnership, limited liability company, S corporation, estate, or trust. A taxpayer must also meet the requirement of 2006 Iowa Acts, Senate File 2268, section 2 Iowa Code section 175.37.

AGRICULTURAL DEVELOPMENT AUTHORITY[25](cont'd)

ITEM 4. Amend subrule 6.2(1) as follows:

6.2(1) Eligibility. To qualify for this credit, the taxpayer must meet all the requirements of Iowa Code chapter 9H or 9I, ~~2006 Iowa Acts, Senate File 2268, section 2~~ Iowa Code section 175.37, and these rules. The beginning farmer must meet all the requirements of Iowa Code section 175.12 and these rules.

ITEM 5. Amend subrule 6.5(1) as follows:

6.5(1) Either the beginning farmer or the taxpayer shall immediately notify the authority of any material changes in the agricultural assets transfer agreement. The authority shall act upon these changes pursuant to ~~2006 Iowa Acts, Senate File 2268, section 2~~ Iowa Code section 175.37. Material changes cannot result in an increase in the original tax credit amount approved. Death of a party to the lease, divorce, or sale of the property will be considered eligible material changes. Sale of the property will be considered only if the original lease terms remain in effect and the asset purchaser is determined to be eligible for the program.

ITEM 6. Amend **25—Chapter 6**, implementation sentence, as follows:

These rules are intended to implement Iowa Code chapter 175 as amended by ~~2006 Iowa Acts, Senate File 2268.~~

[Filed Emergency After Notice 1/16/13, effective 1/16/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0576C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 225C.6(1) and 2012 Iowa Acts, chapter 1120, section 38, the Department of Human Services amends Chapter 25, "Disability Services Management," Iowa Administrative Code.

These amendments establish criteria for exempting counties from joining into regions to administer mental health and disability services. The Department is charged with implementing the redesign of the mental health and disability services system into a regionally administered, locally delivered service system. The authority to accept applications for an exemption is repealed effective July 1, 2013.

The Department was given emergency rule-making authority due to the requirements in the Iowa Code for counties to voluntarily form mental health and disability services regions by April 1, 2013, or to submit a letter of intent by May 1, 2013, to apply for an exemption from forming into a region of at least three contiguous counties.

Pursuant to Iowa Code section 17A.4(3), the Mental Health and Disability Services Commission finds that notice and public participation are impractical because the Legislature mandated these changes in 2012 Iowa Acts, chapter 1120, division IV, section 38, and the authority to accept applications for an exemption is repealed effective July 1, 2013.

Pursuant to Iowa Code section 17A.5(2)"b"(1), the Mental Health and Disability Services Commission further finds that the normal effective date of these amendments, 35 days after publication, should be waived and the amendments made effective January 8, 2013, as authorized by 2012 Iowa Acts, chapter 1120, division IV, section 38, to allow sufficient time for counties to apply for exemption from joining other counties in regions for the purpose of providing mental health and disability services.

These amendments are also published herein under Notice of Intended Action as **ARC 0575C** to allow for public comment.

These rules do not provide for waivers in specific situations because the legislation does not allow for waivers. Request for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

HUMAN SERVICES DEPARTMENT[441](cont'd)

These amendments are intended to implement Iowa Code section 331.389.

These amendments became effective January 8, 2013, after review by the Administrative Rules Review Committee.

The following amendments are adopted.

ITEM 1. Amend **441—Chapter 25**, preamble, as follows:

This chapter provides for reporting of county expenditures, development and submission of management plans, data collection, and applications for funding as they relate to county service systems for people with mental illness, chronic mental illness, ~~mental retardation~~, intellectual disabilities, developmental disabilities, or brain injury.

ITEM 2. Reserve rules **441—25.82** to **441—25.90**.

ITEM 3. Adopt the following new Division VIII title in **441—Chapter 25**:

DIVISION VIII
CRITERIA FOR EXEMPTING COUNTIES FROM JOINING INTO REGIONS
TO ADMINISTER MENTAL HEALTH AND DISABILITY SERVICES

ITEM 4. Adopt the following new rule 441—25.91(331):

441—25.91(331) Exemption from joining into mental health and disability services region.

25.91(1) Definitions.

“Applicant” means a single county or two counties that submit an application for an exemption from the requirement to join a region of three or more contiguous counties.

“Clear lines of accountability” means the governing board’s organizational structure makes it evident that the ultimate responsibility for the administration of non-Medicaid-funded mental health and disability services lies with the governing board and that the governing board directly and solely supervises the organization’s chief executive officer.

“Coordinator of disability services” means a person who meets the qualifications of a coordinator of disability services as defined in Iowa Code section 331.390(3) “b” and is responsible for ensuring that individuals receive effective service coordination consistent with the county’s or counties’ management plan.

“Core services” means core services mandated to be provided by the regional service system as defined in Iowa Code section 331.397.

“Department” means the Iowa department of human services.

“Director” means the director of the department.

“Evidence-based practice” means interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial, and effective.

“Penetration rate,” for the purposes of this rule, means the per capita number of adults in the adult population of a county who are receiving mental health and disability services.

“Reasonably close proximity” means a distance of 100 miles or less or a driving distance of two hours or less from the county seat or county seats of the applicant.

“Trauma-informed care” means services that are based on an understanding of the vulnerabilities or triggers of individuals who have experienced trauma, recognize the role trauma has played in the lives of those individuals, are supportive of trauma recovery, and avoid retraumatization.

25.91(2) Application for exemption from the requirement to form a region of three or more contiguous counties. The following requirements apply to an application for exemption from the requirement to form a region of three or more contiguous counties:

a. The applicant shall submit a written statement that the applicant intends to apply for an exemption from the requirement to form a region of three or more contiguous counties. The statement must be signed by the chairperson of the county board of supervisors of the applicant’s county. The signed written statement of intent must be received by the department on or before May 1, 2013, at 4:30 p.m.

HUMAN SERVICES DEPARTMENT[441](cont'd)

b. The applicant shall submit a written application on forms specified by the department with required supporting documentation. The department shall only accept applications that are complete, signed by the applicant's chairperson of the county board of supervisors, dated, and received by the department on or before June 30, 2013, at 4:30 p.m.

c. The director of the department shall issue a decision on the application within 45 days of receiving the application. The director shall deny an application if the application does not meet the criteria described in Iowa Code or rule.

25.91(3) Applicant criteria. The application shall include written documentation and evidence that the applicant has:

a. The capacity to provide required core services and perform required functions described in Iowa Code section 331.397.

b. A contract with a community mental health center or a federally qualified health center that provides psychiatric and outpatient mental health services in the applicant's county or counties or written intent from the community mental health center or federally qualified health center to enter into such a contract.

c. A contract with a hospital with an inpatient psychiatric unit or a state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services to the applicant or written intent from the state mental health institute or inpatient psychiatric unit to enter into such a contract.

d. An administrative structure with clear lines of accountability. A description of the applicant's administrative functions shall be included with the application.

e. Taken steps to determine and demonstrate that forming a region of three or more contiguous counties is not workable.

25.91(4) Core services and required functions standards. The department shall review the application to determine if the applicant has provided written documentation and evidence for the availability of:

a. A 24-hour, 7-day-a-week, 365-days-per-year telephone response system for mental health and disability-related emergencies in the applicant's county or counties.

b. Service providers in the applicant's county or counties that demonstrate the capability of providing evidence-based practices that the applicant has independently verified meet established fidelity to evidence-based service models including, but not limited to:

- (1) Assertive community treatment or strengths-based case management.
- (2) Integrated treatment of co-occurring substance abuse and mental health disorders.
- (3) Supported employment.
- (4) Family psychoeducation.
- (5) Illness management and recovery.
- (6) Permanent supportive housing.

c. Service providers in the applicant's county or counties that are trained to provide effective services to persons with two or more of the following co-occurring conditions: mental illness, intellectual disability, developmental disability, brain injury, or substance use disorder. Training for serving persons with co-occurring conditions shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the application.

d. Service providers in the applicant's county or counties that are trained to provide effective trauma-informed care. Trauma-informed care training shall be training identified by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the application.

25.91(5) Service capacity. The department shall review the material provided in the application and by the applicant and other counties in their required county reports to determine if the applicant demonstrates that it has:

- a. Sufficient financial resources to fund required core services.

HUMAN SERVICES DEPARTMENT[441](cont'd)

b. A penetration rate that is at least equal to or exceeds the statewide per capita average for individuals with a mental illness or individuals with an intellectual disability.

c. A per capita use of inpatient psychiatric hospital services that is less than or equal to the statewide per capita average.

d. A per capita use of intermediate care facilities for individuals with intellectual disabilities that is less than or equal to the statewide per capita average.

e. A per capita use of outpatient mental health services that is greater than or equal to the statewide per capita average.

f. A per capita use of supported community living services that is greater than or equal to the statewide per capita average.

g. An average cost of service per individual served that is equal to or less than the statewide average.

h. Administrative costs, as a percentage of non-Medicaid service expenditures, that are less than or equal to the statewide average.

25.91(6) Provider network sufficiency. The department shall review the application to determine if the applicant provided written documentation and evidence of:

a. A contract with a community mental health center that provides services in the applicant's county or counties or a federally qualified health center that provides psychiatric and outpatient mental health services in the applicant's county or counties or written intent by a community mental health center or federally qualified health center to enter into such a contract.

b. Contracts with licensed and accredited providers to provide each service in the required core service domains or written intent by providers to enter into such contracts.

c. Adequate numbers of licensed and accredited providers to ensure availability of core services so that there is no waiting list for services due to lack of available providers.

d. A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity or written intent by an inpatient psychiatric hospital unit or state mental health institute to enter into such a contract.

25.91(7) to 25.91(9) Reserved.

25.91(10) Staffing. The department shall review the application to determine if the applicant provided written documentation and evidence of:

a. Clear lines of accountability.

b. The inclusion of one or more coordinators of disability services on the county administrator staff.

25.91(11) Reserved.

25.91(12) Determination that formation of a region is unworkable. The department shall review the application to determine if the applicant has provided documentation and convincing evidence that the applicant has evaluated the feasibility of forming into a region of three or more contiguous counties and that forming into such a region is unworkable.

25.91(13) Compliance with requirements of a mental health and disability services region. The applicant shall continuously fulfill all of the requirements of a region under Iowa Code chapters 331 and 225C for a regional service system, regional service system management plan, regional governing board, and regional administrator and any other requirements applicable to a region of counties providing local mental health and disability services. If the applicant does not fulfill these requirements, the department may address the deficiencies in the following order:

a. Require compliance with a corrective action plan that may include, but is not limited to, participation in technical assistance provided or arranged by the department, revision of the regional management plan, or other corrective actions required by the department.

b. Reduce the amount of the annual state funding provided through the mental health and disabilities regional services fund for the regional service system, not to exceed 15 percent of the amount of the annual state funding.

HUMAN SERVICES DEPARTMENT[441](cont'd)

- c. Withdraw approval for the county exemption.
This rule is intended to implement Iowa Code section 331.389.

[Filed Emergency 1/8/13, effective 1/8/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0585C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services adopts amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

The Health Care and Education Reconciliation Act of 2010 (HCERA), Section 1202 (Public Law 111-152) (42 U.S.C. § 1396a(a)(13)(C)), requires that state Medicaid programs increase payments to primary care specialties specified under Section 1202 of the Act. In particular, HCERA identifies the following specialty designations: "family medicine," "general internal medicine," and "pediatric medicine." The payment requirement specifies that reimbursement must be "... at a rate not less than 100 percent of the payment under Part B of title XVIII [Medicare]." Section 1202 of the Act also specifies the types of services that fall under this requirement. Those services include: (1) services designated as "evaluation and management" under the healthcare common procedure coding system (HCPCS), as of December 31, 2009 (and subsequently modified), which are current procedural terminology (CPT) codes in the ("evaluation and management") range 99201-99499; and (2) services related to immunization administration, billed with current CPT codes 90460, 90461, 90471, 90472, 90473 and 90474.

Section 1202 of the Act also requires that these same changes be made for Medicaid managed care plans. In that regard, such changes are being effectuated by contract amendments with the current (and only) medical managed care plan administered by Meridian Health Plan. Beyond Meridian, there are no other managed care plans that would be affected. Because these changes are being addressed via contract amendment, there are no changes being made to managed care rules under 441—Chapter 88.

Section 1202 of the Act specifies that these increased payments are only to be in effect for calendar years 2013 and 2014.

Final regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) allow for two criteria to identify the applicable practitioners meeting the requirements of Section 1202 of the Act:

1. The first method is board certification by the national specialty boards applicable to each specified group (i.e., the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA)).
2. The second method is claims history of at least 60 percent of a given practitioner's Medicaid claims attributable to the primary care services (i.e., procedure codes) specified under Section 1202 of the Act. Providers must certify that they meet one or both of these criteria.

The Council on Human Services adopted these amendments on January 9, 2013.

Pursuant to Iowa Code section 17A.4(3), the Department finds that notice and public participation are unnecessary because they are impracticable. Recently CMS finalized rules pursuant to Section 1202 of the Act which specify that these changes must be implemented by January 1, 2013. However, because CMS did not issue final rules until November 6, 2012, combined with uncertainty on how these changes would need to be implemented, the Department was unable to move forward until this time.

In addition, failure to waive notice would be contrary to the public interest. The increased payments for primary care services and providers as specified in Section 1202 of the Act will expand access to these services for the public.

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Pursuant to Iowa Code section 17A.5(2)“b”(2), the Department further finds that the normal effective date of these amendments, 35 days after publication, should be waived and the amendments made effective January 9, 2013. The implementation period can be waived since the rule making confers a benefit on the public. The increased payments to primary care providers will confer a benefit on the public, as well as for qualifying Medicaid providers, which will in turn increase access to the specified primary care services.

These amendments are also published herein under Notice of Intended Action as **ARC 0584C** to allow for public comment.

These amendments do not provide for waiver in specified situations because the amendments confer a benefit of increased payment to identified primary care providers specified under Section 1202 of the Act. Requests for waiver of any rule may be submitted under the Department’s general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, there is a potential for positive impact on private sector jobs. According to CMS, “the overall benefit of this rule is the expected increase in provider participation [in Medicaid] by primary care physicians resulting in better access to primary and preventive health services by Medicaid beneficiaries.” 77 Fed. Reg. 66670 (Nov. 6, 2012). On that basis, there will be a positive impact on private sector jobs and employment opportunities for primary care physicians and associated personnel.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments became effective January 9, 2013.

The following amendments are adopted.

ITEM 1. Amend subrule **79.1(2)**, provider category “Physicians (doctors of medicine or osteopathy),” as follows:

Provider category	Basis of reimbursement	Upper limit
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/12 less 2%.
<u>Qualified primary care services furnished in 2013 or 2014</u>	<u>See 79.1(7)“c”</u>	<u>Rate provided by 79.1(7)“c”</u>

ITEM 2. Adopt the following **new** paragraph **79.1(7)“c”**:

c. Payment for primary care services furnished in 2013 or 2014. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar years 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and Management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty

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designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7) "c") equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7) "c"), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service.

(4) Primary care services eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(A)(1).

(5) Notwithstanding the foregoing provisions of this paragraph (79.1(7) "c"), payment for the administration of vaccines provided under the vaccines for children program in calendar years 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the vaccines for children program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

[Filed Emergency 1/9/13, effective 1/9/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0586C

PUBLIC HEALTH DEPARTMENT[641]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 139A.8(8), the Department of Public Health hereby amends Chapter 7, "Immunization and Immunization Education: Persons Attending Elementary or Secondary Schools, Licensed Child Care Centers or Institutions of Higher Education," Iowa Administrative Code.

The rules in Chapter 7 describe the immunization requirements of persons attending elementary or secondary school and licensed child care centers in Iowa. On November 14, 2012, the State Board of Health adopted amendments to this chapter which included replacing the Immunization Requirements Table to add a vaccination for tetanus, diphtheria and pertussis (Tdap vaccine) for students in secondary school and adding a new footnote "2," which required renumbering the subsequent footnotes. Those amendments were Adopted and Filed and published in the Iowa Administrative Bulletin on December 12, 2012, as **ARC 0481C**. Prior to the adoption of the revised table in November, the cell in the table labeled "Total Doses Required" for Tdap vaccine for Elementary or Secondary School (K-12) read as follows:

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Vaccine	Total Doses Required
Diphtheria/Tetanus/Pertussis ^{3, 4}	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003. ² DTaP is not indicated for persons 7 years of age and older, therefore, a tetanus-and diphtheria-containing vaccine should be used.

The change to the table adopted in November took the last statement in the “Total Doses Required” cell and made it new footnote “2,” while adding the one-time dose for grades 7 and above. The table as adopted in November reads as follows:

Diphtheria/Tetanus/ Pertussis ^{4, 5}	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000 ² ; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003 ² ; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003 ³ ; and 1 time dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) for applicants in grades 7 and above, if born on or after September 15, 2000, regardless of the interval since the last tetanus/diphtheria-containing vaccine.
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¹ Mumps vaccine may be included in measles/rubella-containing vaccine.

² DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus-and diphtheria-containing vaccine should be used.

³ The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.

After publication, an omission was noticed. The statement that begins with “5 doses” needs to include footnote 2 as well as footnote 3. This maintains current practice. The table adopted in this emergency filing corrects this oversight.

Pursuant to Iowa Code section 17A.4(3), the Department finds that notice and public participation are impracticable because this amendment corrects an omission in the amendments adopted on November 14, 2012, which would have become effective on January 16, 2013.

The Department also finds, pursuant to Iowa Code section 17A.5(2)“b”(2), that the normal effective date of this amendment should be waived and this amendment should be made effective on January 16, 2013, as the amendment confers a benefit by correcting an omission.

The State Board of Health adopted this amendment on January 9, 2013.

After analysis and review of this rule making, no impact on jobs has been found.

This amendment is intended to implement Iowa Code section 139A.8.

This amendment became effective on January 16, 2013.

The following amendment is adopted.

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Rescind the Immunization Requirements Table in subrule 7.4(1) and adopt the following **new** table in lieu thereof:

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. Routine vaccination begins at 2 months of age.	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio	1 dose
		<i>haemophilus influenzae</i> type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio	2 doses
		<i>haemophilus influenzae</i> type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio	2 doses
		<i>haemophilus influenzae</i> type B	2 doses; or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio	3 doses
		<i>haemophilus influenzae</i> type B	3 doses, with the final dose in the series received on or after 12 months of age, or 1 dose received when the applicant is 15 months of age or older.
		Pneumococcal	4 doses; or 3 doses if the applicant received 1 or 2 doses before 12 months of age; or 2 doses if the applicant has not received any previous doses or has received 1 dose on or after 12 months of age.
		Measles/Rubella ¹	1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.
	24 months and older	Diphtheria/Tetanus/Pertussis	4 doses
Polio		3 doses	
<i>haemophilus influenzae</i> type B		3 doses, with the final dose in the series received on or after 12 months of age; or 1 dose received when the applicant is 15 months of age or older. Hib vaccine is not indicated for persons 60 months of age or older.	
Pneumococcal		4 doses if the applicant received 3 doses before 12 months of age; or 3 doses if the applicant received 2 doses before 12 months of age; or 2 doses if the applicant received 1 dose before 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age. Pneumococcal vaccine is not indicated for persons 60 months of age or older.	
Measles/Rubella ¹		1 dose of measles/rubella-containing vaccine received on or after 12 months of age; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.	
Varicella		1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, unless the applicant has had a reliable history of natural disease.	
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/Pertussis ^{4, 5}	3 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or before September 15, 2000 ⁴ ; or 4 doses, with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born after September 15, 2000, but before September 15, 2003 ² ; or 5 doses with at least 1 dose of diphtheria/tetanus/pertussis-containing vaccine received on or after 4 years of age if the applicant was born on or after September 15, 2003 ^{2, 3} ; and 1 time dose of tetanus/ diphtheria/acellular pertussis-containing vaccine (Tdap) for applicants in grades 7 and above, if born on or after September 15, 2000; regardless of the interval since the last tetanus/diphtheria containing vaccine.
		Polio ⁷	3 doses, with at least 1 dose received on or after 4 years of age if the applicant was born on or before September 15, 2003; or 4 doses, with at least 1 dose received on or after 4 years of age if the applicant was born after September 15, 2003. ⁶
		Measles/Rubella ¹	2 doses of measles/rubella-containing vaccine; the first dose shall have been received on or after 12 months of age; the second dose shall have been received no less than 28 days after the first dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses if the applicant was born on or after July 1, 1994.
		Varicella	1 dose received on or after 12 months of age if the applicant was born on or after September 15, 1997, but born before September 15, 2003, unless the applicant has had a reliable history of natural disease; or 2 doses received on or after 12 months of age if the applicant was born on or after September 15, 2003, unless the applicant has a reliable history of natural disease. ⁸

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- ¹ Mumps vaccine may be included in measles/rubella-containing vaccine.
- ² DTaP is not indicated for persons 7 years of age or older, therefore, a tetanus-and diphtheria-containing vaccine should be used.
- ³ The 5th dose of DTaP is not necessary if the 4th dose was administered on or after 4 years of age.
- ⁴ Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine before 12 months of age should receive a total of 4 doses, with one of those doses administered on or after 4 years of age.
- ⁵ Applicants 7 through 18 years of age who received their 1st dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one of those doses administered on or after 4 years of age.
- ⁶ If an applicant received an all-inactivated poliovirus (IPV) or all-oral poliovirus (OPV) series, a 4th dose is not necessary if the 3rd dose was administered on or after 4 years of age.
- ⁷ If both OPV and IPV were administered as part of the series, a total of 4 doses are required, regardless of the applicant's current age.
- ⁸ Administer 2 doses of varicella vaccine, at least 3 months apart, to applicants less than 13 years of age. Do not repeat the 2nd dose if administered 28 days or greater from the 1st dose. Administer 2 doses of varicella vaccine to applicants 13 years of age or older at least 4 weeks apart. The minimum interval between the 1st and 2nd dose of varicella for an applicant 13 years of age or older is 28 days.

[Filed Emergency 1/9/13, effective 1/16/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0594C

ENVIRONMENTAL PROTECTION COMMISSION[567]

Adopted and Filed

Pursuant to the authority of Iowa Code section 455B.105, the Environmental Protection Commission (Commission) hereby adopts new Chapter 17, "Compliance and Enforcement Procedures," Iowa Administrative Code.

The purpose of Chapter 17 is to affirm the variety of compliance and enforcement documents the Department of Natural Resources (Department) may consider using in responding to possible violations of environmental statutes, rules, permits, licenses, certifications, and plans. The Department has used these or similar procedures for many years, and this chapter simply formalizes this practice.

Notice of Intended Action was published in the Iowa Administrative Bulletin on March 21, 2012, as **ARC 0051C**, and a public hearing was held on April 23, 2012. An Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on May 16, 2012, as **ARC 0126C**, extending the public comment period to August 16, 2012. A second Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on June 27, 2012, as **ARC 0182C**, adding three additional public hearings and providing more information on the Department's intended implementation for the proposed rules.

Summary: Public Comments and Response to Comments

The Department received a total of 909 comments on the proposed rule making; 842 comments were written comments, and 67 comments were oral comments provided at the four public hearings.

The public participation responsiveness summary prepared by the Department is available on the Department's Web site on the Environmental Protection Commission page. (Go to <http://www.iowadnr.gov/InsideDNR/BoardsCommissions/EnvironmentalProtectionEPC.aspx> and click on the link for the meeting information for January 15, 2013.) In addition, the public participation responsiveness summary, an Excel spreadsheet with the logged comments, the written transcripts of the public hearings, and a link to an FTP site with access to all written comments are available from the Department's Web site at <http://www.iowadnr.gov/idnr/InsideDNR/RegulatoryAir/StakeholderInvolvement/PublicInput.aspx>.

Most of the comments submitted were opposed to the proposed rules and commented that the proposed rules would weaken the Department's ability to enforce environmental requirements. These commenters expressed concern that the new rules favor large industrial or agricultural interests and that the Department will not fine or penalize those who violate rules or permits established to protect public health and the environment. The commenters were particularly concerned about manure spills, fish kills, and impacts to water quality but also expressed concern about weakened enforcement of all environmental regulations. The majority of comments opposed to the rule making advocated for the termination of the rule making.

The Department carefully considered the comments asserting that the rules in Chapter 17 will weaken the Department's enforcement of environmental regulations, including regulations applicable to animal feeding operations. The Department continues to be fully committed to taking appropriate enforcement action in response to violations, including entering into administrative consent orders or issuing administrative orders that assess penalties and require corrective action, and recommending that the Commission refer violations to the Attorney General.

The new chapter simply illustrates how the Department already works with regulated entities to ensure that regulated entities understand how environmental requirements apply to them, how to comply with these requirements, and what the consequences are if they violate these requirements. Additionally, the rules in the new chapter in no way preclude the Department or the Commission from pursuing administrative enforcement as specified in 567—Chapter 10, referral to the Attorney General, or other enforcement actions allowed under Iowa statute.

The activities and compliance documents in this chapter are not intended to be a hierarchy of the Department's actions in response to a specific violation, nor are these activities intended to be mutually

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exclusive. A listed activity may not be appropriate for a specific violation. The listed activities are meant to be tools that the Department may use, and use of these tools is solely at the Department's discretion.

Further, the Department has attempted to illustrate the circumstances under which the Department would typically apply the specific compliance activities included in the proposed chapter. The Department provided examples, which are not inclusive of all possible scenarios or Department actions, in the second Amended Notice of Intended Action (**ARC 0182C**, available at <https://www.legis.iowa.gov/DOCS/ACO/IAC/LINC/ARC.0182C.pdf>). The Department is committed to further improving its implementation procedures to ensure a clear and appropriate compliance and enforcement response to environmental violations.

The Department also received comments in support of Chapter 17. In general, the supportive comments expressed that the proposed new chapter would allow the Department to use a wider range of communication options for notification of noncompliance issues and would allow the Department to exercise fair discretion for a wide variety of circumstances in several different areas of environmental protection. Other comments suggested that the proposed rules would improve the cooperation of regulated entities and prevent violations.

To address comments received, the Commission made a change to adopted Chapter 17 from what was proposed in the Notice of Intended Action (**ARC 0051C**). A new sentence is added at the end of rule 567—17.3(455B) and reads as follows: "Nothing in this chapter adds to or takes away from the appeal rights provided in Iowa Code chapter 17A." This new language is intended to make clear that nothing in this rule making affects applicable appeal rights, especially for those who believe usage of a document listed in the rule gives rise to a contested case proceeding in a particular situation. The Department did not make any other changes to adopted Chapter 17 from what was proposed in the Notice of Intended Action.

After analysis and review of this rule making, no adverse impact on jobs exists. Chapter 17 promotes communication between regulated entities and the Department by encouraging compliance with rules and regulations. The new chapter will provide a benefit to regulated entities and to the public by clarifying the variety of compliance and enforcement documents that the Department may consider in responding to possible violations, while still preserving the Department's enforcement discretion.

These rules are intended to implement Iowa Code section 455B.105.

These rules will become effective on March 13, 2013.

The following amendment is adopted.

Adopt the following **new** 567—Chapter 17:

CHAPTER 17
COMPLIANCE AND ENFORCEMENT PROCEDURES

567—17.1(455B) Scope. Prior to the initiation of administrative penalties pursuant to 567—Chapter 10, the department may consider other compliance and enforcement activities. This chapter sets out the possible compliance and enforcement procedures that the department may consider and utilize.

567—17.2(455B) Basis. While serious violations of rules, regulations and permits may result in administrative penalties, many activities by regulated entities may not rise to the level of requiring such formal enforcement action. In some instances, development of additional facts is appropriate, and in other instances, notification of the nature of the violation with an opportunity to correct the violation may be sufficient. The following compliance and enforcement procedures are available to the department and may be considered in those instances where it is necessary for the department to undertake a compliance or enforcement initiative:

17.2(1) Informal meeting. Department staff may attempt to resolve a potential violation or obtain additional information with an informal meeting. This meeting may be at the facility where the inspection took place. The discussion will usually focus on corrective actions to be taken, and in most instances, only department staff and the facility representative are present.

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17.2(2) Letter of inquiry (LOI). If an informal meeting is not practical or is insufficient, the department may issue a letter of inquiry (LOI). The purpose of the LOI is to allow the regulated entity the opportunity to provide information that would be helpful for a determination of whether a violation has occurred. The letter should be labeled “Letter of Inquiry” and should, to the extent possible, seek specific information that will aid in the enforcement review.

17.2(3) Letter of noncompliance (LNC). If the information available to the department indicates a violation has taken place, the department may issue a letter of noncompliance (LNC). This letter is used to address violations of a less significant nature, such as a single incident of late reporting. An LNC will most often be used when no environmental harm or threat to human health or safety has occurred or is imminent, the regulated entity is not a repeat offender, the corrective action is not deemed an emergency, or the violation is considered insignificant. The letter is similar to a notice of violation but is captioned “Letter of Noncompliance” and is intended to provide the regulated entity with an opportunity to correct the identified deficiencies prior to further enforcement activity. In the LNC, the department also may suggest remedial measures and set a date for returning to compliance. The department will usually request a response from the regulated entity within a specific time period as to how the identified problems will be resolved. The LNC will typically be followed by a notice of violation if the regulated entity does not respond.

17.2(4) Notice of violation (NOV). When the other compliance and enforcement activities described in this chapter are not appropriate for the violation, or when the regulated entity has not returned to compliance, the department may issue a notice of violation (NOV). An NOV will most often be used when environmental harm or a threat to human health or safety has occurred or is imminent, the regulated entity is a repeat offender, the corrective action is deemed an emergency, or the violation is considered significant. The NOV identifies the nature of the violation and any corrective action being required of the regulated entity.

567—17.3(455B) Option to respond. Upon receiving a written inquiry, letter, or notice from the department as described in this chapter, the regulated entity has the option to respond to the department even if a response is not specifically requested. A letter of noncompliance (LNC) or notice of violation (NOV) will typically suggest a written response and corrective action from the regulated entity within a specified time period. In responding to an LNC or NOV, the regulated entity should, as appropriate, clearly outline any disagreements with the department’s LNC or NOV, provide any pertinent additional information, describe any current or planned corrective action, and provide a schedule for returning to compliance. The department will review written information submitted in response to the compliance and enforcement procedures described in this chapter and will include this information in the file of record. Nothing in this chapter adds to or takes away from the appeal rights provided in Iowa Code chapter 17A.

567—17.4(455B) Department discretion. At the department’s sole discretion, the department may follow the compliance and enforcement procedures described in this chapter, commence with an LNC or NOV, or forego these options and commence with an administrative action (567—Chapter 10), or the department may request referral to the attorney general. The procedures in this chapter are intended to inform the regulated community of possible forms of compliance and enforcement procedures available to the department.

These rules are intended to implement Iowa Code section 455B.105.

[Filed 1/16/13, effective 3/13/13]

[Published 2/6/13]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0583C**HUMAN SERVICES DEPARTMENT[441]****Adopted and Filed**

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 7, "Appeals and Hearings," and Chapter 88, "Managed Health Care Providers," Iowa Administrative Code.

These amendments add language to ensure that managed care organization (MCO) network providers who seek a state fair hearing on behalf of a Medicaid member have involved the member and have that member's specific consent to pursue a state fair hearing.

These amendments conform the rules of the Department to federal regulations that require consent of the member when a network provider requests a hearing. 42 CFR 438.402 specifically requires written consent of the member.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0435C** on October 31, 2012.

As the result of internal review of the proposed amendments, the following changes were made to the amendments published under Notice of Intended Action:

New Items 1 and 2 were added to amend Chapter 7, "Appeals and Hearings," for clarity and consistency in the processing of appeals where state fair hearings have been requested by providers. As a consequence, proposed Items 1 and 2 were renumbered as Items 3 and 4.

New subrules 88.8(6) and 88.68(7) in Items 3 and 4 have been revised to ensure that a state fair hearing will only be granted when a network provider submits a document providing member approval of the request with the request for state fair hearing. Specifically, the final sentence in subrule 88.8(6) and subrule 88.68(7) has been omitted to eliminate the instruction for administrative law judges to dismiss any request for a state fair hearing that does not comply with all the requirements of the subrule. If the member's approval is not submitted with the request for fair hearing, the fair hearing request will be denied by the Appeals Section of the Department.

The Council on Human Services adopted these amendments on January 9, 2013.

These amendments do not provide for waivers in specified situations because all Medicaid providers who are members of a managed care organization (MCO) should be subject to the same requirements. However, requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective April 1, 2013.

The following amendments are adopted.

ITEM 1. Amend rule **441—7.1(17A)**, definition of "Aggrieved person," as follows:

"*Aggrieved person*" means a person against whom the department has taken an adverse action. This includes a person who meets any of the following conditions:

1. to 6. No change.
7. For providers, a person or entity:
 - Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.
 - Whose claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.
 - Whose contract as a Medicaid patient manager has been terminated.
 - Who has been subject to the withholding of a payment to recover a prior overpayment or who has received an order to repay an overpayment pursuant to 441—subrule 79.4(7).
 - Who has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome.

HUMAN SERVICES DEPARTMENT[441](cont'd)

- Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.
- Who has been subject to an adverse action related to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A).
- Who, as a managed care organization (MCO) provider or Iowa plan contractor when acting on behalf of a member, has a dispute regarding payment of claims.

8. to 12. No change.

ITEM 2. Amend paragraph 7.5(2)“a” as follows:

a. One of the following issues is appealed:

(1) to (17) No change.

(18) An MCO provider or Iowa plan contractor fails to submit a document providing the member's approval of the request for appeal.

ITEM 3. Adopt the following **new** subrule 88.8(6):

88.8(6) *Consent for state fair hearing.* Network providers which are contracted and in good standing with a medical managed care organization (MCO) may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member 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 member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

ITEM 4. Adopt the following **new** subrule 88.68(7):

88.68(7) *Consent for state fair hearing.* Network providers which are contracted and in good standing with the Iowa plan contractor may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member 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 member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[Filed 1/9/13, effective 4/1/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0573C**HUMAN SERVICES DEPARTMENT[441]****Adopted and Filed**

Pursuant to the authority of Iowa Code section 225C.6(1) and 2012 Iowa Acts, Senate File 2315, section 23, the Department of Human Services adopts new Chapter 23, “Mental Health and Disability Services Redesign Transition Fund,” Iowa Administrative Code.

These rules developed pursuant to 2012 Iowa Acts, Senate File 2315, section 23, and 2012 Iowa Acts, Senate File 2336, sections 56 and 66, are intended to provide for the gathering of information and to guide the development of recommendations to the Governor and Legislature regarding appropriations for transition funds to continue non-Medicaid-funded current core county mental health and disability services.

The rules are divided into the following sections:

1. Definitions.
2. Eligibility requirements.
3. Establishment of application guidelines related to financial need, financial data, and sustainability plans.
4. Establishment of guidelines for the Department of Human Services for the receiving, analyzing, and reporting of transition applications as relating to the transition funds.
5. Establishment of guidelines related to the allocation of transition funds.

The rules represent what the Mental Health and Disability Services (MHDS) Commission believes will demonstrate the county’s need for financial assistance to enable the county to continue current core county mental health and disability services in state fiscal year 2013 and sustain such services in future state fiscal years.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0348C** on October 3, 2012. The rules were also Adopted and Filed Emergency and published as **ARC 0346C** on the same date and became effective September 11, 2012. The Department received no comments. These rules are identical to those published under Notice of Intended Action and Adopted and Filed Emergency.

The MHDS Commission adopted these rules January 3, 2013.

These rules do not provide for waivers in specified situations because the legislation does not specifically allow for waivers. Requests for the waiver of any rule may be submitted under the Department’s general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These rules are intended to implement 2012 Iowa Acts, Senate File 2315, section 23, and Senate File 2336, sections 56 and 66.

These rules will become effective April 1, 2013, at which time the Adopted and Filed Emergency rules are hereby rescinded.

The following amendment is adopted.

Adopt the following **new** 441—Chapter 23:

CHAPTER 23
MENTAL HEALTH AND DISABILITY SERVICES
REDESIGN TRANSITION FUND

PREAMBLE

This chapter provides rules for gathering information and guiding the development of recommendations to the governor and legislature for the mental health and disability services transition fund for state fiscal year 2013.

HUMAN SERVICES DEPARTMENT[441](cont'd)

441—23.1(225C,84GA,SF2315) Definitions.

“*Commission*” or “*MHDS commission*” means the mental health and disability services commission.

“*County-operated program*” means services directly provided by county employees.

“*Current core county mental health and disability services*” means those services defined in the county management plan approved by the commission and effective as of June 30, 2012.

“*Department*” means the Iowa department of human services.

“*Documentation information and materials*” means source documents, worksheets, notes, or any written material used in completing the application for transition funds.

“*Independently verified*” means a signed written opinion of accuracy and reasonableness of financial information submitted in the application by the county auditor based on a review and verification of the documentation information and materials used to complete the application.

“*Subsidize*” means that the county provides additional funding for county-operated services over and above amounts reimbursed from third-party payers, including Medicaid or Medicare, or costs in excess of usual and customary charges for the service.

“*Sustainability plan*” means financial estimates and a description of estimates and assumptions used to ensure that services requested to be funded by the transition fund can and will continue when the transition fund is discontinued at the end of state fiscal year 2013.

“*Target population*” means an adult diagnosed with a mental illness as defined in Iowa Code section 4.1(21A) or an individual with an intellectual disability as defined in Iowa Code section 4.1(9A).

“*Transition fund*” means the mental health and disability services redesign transition fund that has been established pursuant to 2012 Iowa Acts, Senate File 2315, section 23, and, once funds have been appropriated, will provide one-time assistance in state fiscal year 2013 to support county continuation of current core county mental health and disability services to target populations not funded by Medicaid.

441—23.2(225C,84GA,SF2315) Eligibility. A county is eligible for one-time transition funds in state fiscal year 2013, once transition funds are appropriated, if the county meets the following eligibility requirements. Each county shall:

1. Demonstrate that the county levy certified for its services fund under Iowa Code section 331.424A for state fiscal year 2013 is the maximum amount authorized by law.
2. Demonstrate that the county’s projected expenditures for state fiscal year 2013, excluding increased costs for county administration and subsidies for county-operated programs, are in excess of the county’s projected available funds for state fiscal year 2013.
3. Demonstrate that a reduction in the amount, scope, and duration of current core county mental health and disability services is necessary in the absence of transition funding.
4. Submit an application that meets the application requirements.

441—23.3(225C,84GA,SF2315) Application requirements. All of the following requirements must be met for a county to be eligible for transition funds.

23.3(1) The application must be:

- a. Submitted using Form 470-5125, MHDS Transition Fund Application, prescribed by the department.
- b. Completed with all forms and information.
- c. Signed by the chairperson of the county board of supervisors, county auditor, and central point of coordination administrator.
- d. Verified independently by the county auditor.
- e. Delivered no later than 4:30 p.m. on November 1, 2012.

23.3(2) The application for transition funds must include the following current core county mental health and disability services information:

- a. County eligibility criteria for an individual to receive county mental health and disability services.
- b. A copy of the copay and sliding fee schedule as established in the county management plan.

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- c. A complete list of fees and copays that the county charges for each service provided.
- d. The number of individuals who received non-Medicaid-funded services paid for by the county in state fiscal year 2012.
- e. The projected number of individuals who will receive non-Medicaid-funded services paid by the county in state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.

23.3(3) The application for transition funds shall include actual unaudited county financial information for state fiscal year 2012 and projected county financial information for state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015 reported on a cash basis.

- a. Financial information regarding available funds.
 - (1) Amount of funds carried forward from the previous state fiscal year excluding any amount received from the risk pool in state fiscal year 2012.
 - (2) Amount of county funding levied and how amount of county funding levied compares with the maximum amount authorized by law.
 - (3) Amount of state fiscal year 2012 risk pool funds awarded to the county listed by the state fiscal year in which risk pool funds were or will be used, including an explanation of any amounts of state fiscal year 2012 risk pool funds that are projected to be returned.
 - (4) Amount of funding received in state fiscal year 2012 through the state payment program for non-Medicaid-funded services for individuals for whom legal settlement has not been determined, including this same amount for projected state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.

b. Financial information regarding expenditures.

- (1) Amount for county administrative costs, excluding administrative costs of county-operated programs, determined using cost allocation methods consistent with principles contained in OMB Circular A-87.
- (2) Total amount needed to pay for expenses due and owing that were incurred in previous state fiscal years including, but not limited to:
 1. County administrative costs.
 2. Provider payments including the cost of services for county-operated programs and excluding any costs that subsidize county-operated programs.
 3. State charges for the cost of services listed by the state fiscal year in which the charge was incurred:
 - Including the county's portion of the nonfederal share of Medicaid.
 - Including the county's share of mental health institutes and state resource centers minus credits.
 - Excluding any state charges that will be forgiven consistent with 2012 Iowa Acts, Senate File 2315, section 27.

(3) Amount paid to private service providers for non-Medicaid-funded services.

(4) Amount paid for non-Medicaid-funded county-operated programs including an allocation of administrative costs for such services consistent with principles contained in OMB Circular A-87 and excluding any amounts to subsidize county-operated programs.

(5) Service expenditures reported in subparagraphs 23.3(3) "b"(3) and (4) above shall be divided into the following eligibility categories:

1. Individuals in the target population whose income is equal to or less than 150 percent of the federal poverty level.
2. Individuals in the target population whose income is greater than 150 percent of the federal poverty level.
3. Individuals with a disability other than the target population whose income is equal to or less than 150 percent of the federal poverty level.
4. Individuals with a disability other than the target population whose income is greater than 150 percent of the federal poverty level.

c. The county shall retain the county's documentation information and materials used to complete the application for transition funding and shall have this documentation information and materials available for review by the department or its designee.

HUMAN SERVICES DEPARTMENT[441](cont'd)

23.3(4) For a county to be considered for transition funds, it must submit a sustainability plan that includes projected expenditures for state fiscal year 2014 and state fiscal year 2015 and a justification for the projections including:

- a.* A description of the facts and assumptions used when estimating revenues and expenditures for state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.
- b.* Identification of key steps that will be taken to ensure that the level of current core county mental health and disability services continues beyond state fiscal year 2013.
- c.* An explanation of how the requested moneys will be used during the transition year to provide services in a manner that shall enable the county to continue to provide services at current levels in future years within the amount of funding the county has available.

441—23.4(225C,84GA,SF2315) Guidelines for the management of transition funds. This rule establishes guidelines for the department for the receiving, analyzing, recommending, and reporting of transition fund applications.

23.4(1) The department shall provide each county's central point of coordination administrator and the county board of supervisors a set of rules for transition funds and a copy of the application form to be used for applying for transition funds.

23.4(2) The department shall only accept county applications that are complete, submitted on the required forms, properly signed, independently verified, and received by the department by 4:30 p.m. on November 1, 2012.

23.4(3) The department shall develop a recommendation regarding the amount of transition funding the county should receive to continue the current core county mental health and disability services. The department's recommendation shall:

- a.* Exclude projected costs that reflect an increase in the amount, scope, or duration of services above that provided in state fiscal year 2012 based on an analysis of the number of individuals served and the cost per individual in state fiscal year 2013, state fiscal year 2014, and state fiscal year 2015.
- b.* Exclude increased costs of county administration above that expended in state fiscal year 2012.
- c.* Include recommendations for adjustments based on a review of the county's documentation information and materials.
- d.* Include costs of current core county mental health and disability services that are in excess of available funds, excluding the costs as shown in paragraphs 23.4(3) "a" and "b" above.

23.4(4) The department's report to the governor and the legislature on December 1, 2012, shall include:

- a.* The names of counties that applied for transition funds.
- b.* The department's recommendation of the amount that the county shall receive to continue current core county mental health and disability services in state fiscal year 2013.
- c.* The department's opinion regarding whether or not the county has a viable sustainability plan.

441—23.5(225C,84GA,SF2315) Allocation of transition funds. The department shall allocate funds to eligible counties consistent with legislative appropriations. If the amount appropriated by the legislature for transition funds is insufficient to provide for the full cost recommended by the department, and the legislation does not state anything to the contrary, the department shall distribute funds based on the following priorities:

1. Individuals in the target population whose income is equal to or less than 150 percent of the federal poverty level.
2. Individuals in the target population whose income is greater than 150 percent of the federal poverty level.
3. Individuals with a disability other than the target population whose income is equal to or less than 150 percent of the federal poverty level.

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4. Individuals with a disability other than the target population whose income is greater than 150 percent of the federal poverty level.

These rules are intended to implement Iowa Code chapter 225C and 2012 Iowa Acts, Senate File 2315, section 23, and 2012 Iowa Acts, Senate File 2336, sections 56 and 66.

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ARC 0579C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 75, "Conditions of Eligibility," Iowa Administrative Code.

These amendments change the Medicaid for Employed People with Disabilities (MEPD) program eligibility rules so that social security cost-of-living adjustments will be counted only in eligibility and premium determinations based on subsequently published poverty levels.

These amendments also eliminate a cross reference in Chapter 75 to subrule 93.114(1) related to the PROMISE JOBS program. The PROMISE JOBS rules were revised several years ago, and the cross-referenced subrule no longer exists. Consequently, subparagraph 75.53(4)"b"(3) is added to state the conditions under which the needs of an adult who is temporarily out of the home can be included in the eligible group for purposes of medical assistance for families with children, as previously provided in the PROMISE JOBS rules.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0432C** on October 31, 2012. The Department received no comments. These amendments are identical to those published under Notice of Intended Action.

These amendments do not provide for waivers in specified situations because the amendments confer a benefit and because all Medicaid members should be subject to the same rules regarding the determination of eligibility and premium liability. In addition, all family-related Medicaid members should also be subject to the same rules regarding the determination of the eligible group. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective April 1, 2013.

The following amendments are adopted.

ITEM 1. Amend subrule 75.1(39) as follows:

75.1(39) Working persons with disabilities.

a. Medical assistance shall be available to all persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.

(4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)"c."

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(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)“a”(1) above.

(6) They have paid any premium assessed under paragraph 75.1(39)“b” below.

b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) to (11) No change.

c. and *d.* No change.

ITEM 2. Amend paragraph 75.53(4)“b” as follows:

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 from the date of entry into the medical institution will result in the individual’s needs being removed from the eligible group.

(2) ~~An individual~~ A child is out of the home to secure education or training as defined for children in paragraph 75.54(1)“b” as long as the child remains a dependent ~~and as defined for adults in 441—subrule 93.114(1), first sentence.~~

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, “education or training” means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

~~(4)~~ (4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4)“b”(1) ~~and (2)~~ through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual’s needs being removed from the eligible group.

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ARC 0580C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 77, “Conditions of Participation for Providers of Medical and Remedial Care,” Chapter 78, “Amount, Duration, and Scope of Medical and Remedial Services,” and Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” Iowa Administrative Code.

These amendments bring the Iowa Medicaid program into compliance with Section 6401 of the Patient Protection and Affordable Care Act (PPACA), which went into effect March 25, 2011. Specifically, the amendments address the new federal requirements that all providers: (1) be screened according to the provider type’s risk for fraud, waste, or abuse, and (2) be enrolled as a Medicaid provider to be eligible

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for Medicaid payments. These changes are required as part of the transparency and program integrity efforts established by, and identified in, the ACA.

The new enrollment procedures will require providers to disclose the identity of those with ownership and controlling interests in the provider's organization as well as the identity of any organization in which the provider may have an ownership or controlling interest.

Providers will be screened according to the requirements of their assigned risk level: limited, moderate, or high. Depending on assigned risk level, providers may undergo a series of certification and licensure checks on national databases, site visits, background checks and fingerprinting.

The changes in the screening and enrollment processes require a contract amendment with the Provider Services Unit of the Iowa Medicaid Enterprise.

Additionally, providers who are not currently required to enroll, including physician assistants and other providers who bill under a facility, will now be able to enroll for the limited purpose of having the prescriptions they write payable to the pharmacy filling those prescriptions.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0434C** on October 31, 2012. The Department received comments from two interested parties on these amendments.

The first commenter expressed concern that in proposed subparagraph 79.14(4)"c"(1), a provider who "receives a Medicaid overpayment" is subject to an increased screening requirement. The commenter also stated that because Medicaid makes overpayment errors, such a requirement would increase a provider's risk level "through no fault of his own."

The Department agreed with the comment and has replaced the words "provider receives a" with the words "provider has an existing" in subparagraph 79.14(4)"c"(1). The replacement language is part of the federal regulation, and Iowa must comply with the minimum requirements of the regulation. This change from the Notice will mean that only those providers who have an existing overpayment at the time of enrollment or reenrollment will be subject to the adjusted screening level. Those providers who may have had an overpayment and have rectified the situation prior to enrollment or reenrollment will not be subject to an adjusted screening level.

The second commenter expressed concern that the proposed amendments would limit the services physician assistants (PAs) could provide to Medicaid members in that PAs would only be able to order and refer items and services. The commenter indicated that the federal statute could be interpreted to permit PAs to continue in providing the care currently authorized by Iowa law and existing Medicaid rules.

The Department agrees that the proposed amendments do appear to limit the services that PAs can provide to Medicaid members. To address the concerns brought forward on behalf of the PAs, the Department has revised the language in Items 1 and 2, specifically rules 441—77.49(249A) and 441—77.50(249A).

These amendments do not provide for waivers in specified situations because the amendments confer a benefit to a provider type (i.e., physician assistants) not previously able to enroll as a Medicaid provider type. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective April 1, 2013.

The following amendments are adopted.

ITEM 1. Adopt the following **new** rule 441—77.49(249A):

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.

HUMAN SERVICES DEPARTMENT[441](cont'd)

ITEM 2. Adopt the following new rule 441—77.50(249A):

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4.

ITEM 3. Amend subrule 78.2(1) as follows:

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

ITEM 4. Amend rule 441—79.14(249A) as follows:

441—79.14(249A) Provider enrollment.

~~79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider provides other than managed care organizations and Medicaid fiscal agents shall begin the enrollment process by contacting completing the provider services unit at appropriate application on the Iowa Medicaid enterprise Web site. to request an application form.~~

~~a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.~~

~~b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.~~

~~c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.~~

~~d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).~~

~~e. An intermediate care facility for persons with mental retardation an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).~~

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

~~a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.~~

~~b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.~~

~~c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.~~

~~d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:~~

~~(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and~~

~~(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.~~

~~e. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.~~

~~79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.~~

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79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3)“a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control any other; or

(5) The ability of a third party to control any member of the affiliation.

~~79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.~~

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

~~79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not~~

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~~to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.~~

~~**79.14(5)** Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.~~

~~**79.14(6)** Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).~~

~~**79.14(6)** A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.~~

~~**79.14(7)** No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.~~

~~**79.14(7)** Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.~~

~~**79.14(8)** Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.~~

~~**79.14(8)** A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).~~

~~**79.14(9)** Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.~~

~~**79.14(9)** No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.~~

~~**79.14(10)** Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.~~

~~**79.14(10)** Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.~~

~~**79.14(11)** Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.~~

~~*a.*—When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.~~

~~*b.*—When the department incurs an informational tax reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.~~

~~(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.~~

~~(2) Payment of the fine may be appealed under 441—Chapter 7.~~

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79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium as identified in 42 CFR §455.470.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

This rule is intended to implement Iowa Code section 249A.4.

[Filed 1/9/13, effective 4/1/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0581C**HUMAN SERVICES DEPARTMENT[441]****Adopted and Filed**

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

Historically, since the habilitation services program began, the upper rate limit for hourly services has been considered to be set higher than the actual cost and the daily rate cap has been considered to be set too low, resulting in providers' submitting requests for exception to policy to exceed the daily home-based habilitation services upper rate cap. These amendments balance the rates.

These amendments:

1. Increase the daily rate cap for home-based habilitation services from \$105.97 to \$200.
2. Change the definition of a daily unit of service for home-based habilitation services from 14 hours to 8 or more hours. A daily unit of service will be when 8 or more hours of direct services are provided during a 24-hour period on average over the course of a calendar month.
3. Maintain the hourly rate cap and limits for home-based habilitation services.
4. Limit the total daily cost for hourly home-based habilitation services to no more than the daily rate cap set for home-based habilitation services.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0436C** on October 31, 2012. The Department received no comments. These amendments are identical to those published under Notice of Intended Action.

These amendments do not contain any waiver provisions because the Department has an established procedure for considering exceptions to policy. A waiver of any of these rules may be requested through that process. In addition, requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective April 1, 2013.

The following amendments are adopted.

ITEM 1. Amend subrule **79.1(2)**, provider category "Home- and community-based habilitation services," as follows:

Provider category	Basis of reimbursement	Upper limit
Home- and community-based habilitation services:		
1. No change.		
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour <u>not to exceed \$6,083 per month, or \$105.97 \$200 per day.</u>
3. to 5. No change.		

ITEM 2. Amend paragraph **79.1(24)"a"** as follows:

a. *Units of service.*

- (1) No change.
- (2) A unit of home-based habilitation is one hour (for up to 7 hours per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for hourly services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2). EXCEPTIONS:

HUMAN SERVICES DEPARTMENT[441](cont'd)

1. ~~A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The hourly unit shall be used when the member receives services for 1 to 7 hours provided during a 24-hour period as an average over a calendar month.~~

2. ~~When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.~~

(3) to (6) No change.

[Filed 1/9/13, effective 4/1/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0582C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 82, "Intermediate Care Facilities for the Mentally Retarded," Iowa Administrative Code.

These amendments change terminology to use the preferred terms "intellectual disability" and "intellectually disabled" rather than "mental retardation" or "mentally retarded."

The Iowa Legislature passed 2012 Iowa Acts, Senate File 2247, which makes similar terminology changes in the Iowa Code. Although that bill does not direct the Department to make rule changes, these amendments are aligned with the intent of the legislation.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0433C** on October 31, 2012. The Department received no comments. These amendments are identical to those published under Notice of Intended Action.

The Council on Human Services adopted these amendments on January 9, 2013.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective April 1, 2013.

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of these amendments [amendments to Ch 82] is being omitted. These amendments are identical to those published under Notice as **ARC 0433C**, IAB 10/31/12.

[Filed 1/9/13, effective 4/1/13]

[Published 2/6/13]

[For replacement pages for IAC, see IAC Supplement 2/6/13.]

ARC 0574C**LABOR SERVICES DIVISION[875]****Adopted and Filed**

Pursuant to the authority of Iowa Code section 89A.3, the Elevator Safety Board hereby amends Chapter 71, "Administration of the Conveyance Safety Program," Iowa Administrative Code.

This amendment authorizes the Labor Commissioner to remove from service an elevator that is operating without a permit. Although by statute it is illegal to operate an elevator without a permit, this amendment sets forth necessary enforcement procedures.

Notice of Intended Action was published in the October 31, 2012, Iowa Administrative Bulletin as **ARC 0411C**. No public comment was received on the proposed amendment. This amendment is identical to that published under Notice of Intended Action.

The purposes of this amendment are to protect the health and safety of the public and implement legislative intent.

No variance procedures are included in this rule. Applicable variance procedures are set forth in 875—Chapter 66.

After analysis and review of this rule making, this amendment will have no impact on jobs.

This amendment is intended to implement Iowa Code chapter 89A.

This amendment shall become effective on March 13, 2013.

The following amendment is adopted.

Amend subrule 71.7(1) as follows:

71.7(1) Operation of equipment covered by this chapter without a current operating permit is prohibited, except as authorized by rules 875—71.6(89A), 875—71.8(89A), and 875—71.20(89A). If operation of a conveyance is prohibited under this rule, the labor commissioner may post notice on the conveyance that it is not to be used. The conveyance may be returned to service only after an operating permit for the conveyance has been issued or reissued.

[Filed 1/8/13, effective 3/13/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0595C**PHARMACY BOARD[657]****Adopted and Filed**

Pursuant to the authority of Iowa Code sections 147.76 and 272C.2, the Board of Pharmacy hereby amends Chapter 2, "Pharmacist Licenses," Iowa Administrative Code.

The amendments require that all pharmacists register with CPE Monitor, a service jointly developed, implemented, and maintained by the National Association of Boards of Pharmacy (NABP) and the Accreditation Council on Pharmaceutical Education (ACPE) for the purpose of recording and maintaining evidence of pharmacists' successful completion of ACPE-accredited provider continuing education activities. Beginning in 2013, ACPE-accredited providers will only report a pharmacist's successful completion of continuing education activities to CPE Monitor and certificates of completion will no longer be issued to pharmacists by those providers. The pharmacist may review his or her record of completed continuing education activities by logging into the pharmacist's CPE Monitor profile, and the Board will be able to verify a pharmacist's successful completion of traditional ACPE-accredited provider continuing education activities by checking the pharmacist's record with CPE Monitor. The amendments also clarify the recording and reporting requirements for non-ACPE provider activities that are not compatible with CPE Monitor.

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The amendments provide pharmacists with the option to complete and submit a continuing professional development (CPD) portfolio to fulfill the continuing education requirements for license renewal or license reactivation. Rule 657—2.17(272C) establishes the requirements for a CPD portfolio including the required content of the portfolio and the process for declaring to the Board the pharmacist's intention to complete and submit a CPD portfolio, identifies a prerequisite for a pharmacist's participation in and submission of a CPD portfolio, and asserts the Board's intention to review and respond to pharmacists who submit CPD portfolios.

Requests for waiver or variance of the discretionary provisions of these rules will be considered pursuant to 657—Chapter 34.

Notice of Intended Action was published in the December 12, 2012, Iowa Administrative Bulletin as **ARC 0511C**. The Board received no written comments regarding the proposed amendments. The adopted amendments are identical to those published under Notice.

The amendments were approved during the January 16, 2013, meeting of the Board of Pharmacy.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 147.10, 147.11, 272C.2, and 272C.3.

These amendments will become effective on March 13, 2013.

The following amendments are adopted.

ITEM 1. Amend rule 657—2.12(272C) as follows:

657—2.12(272C) Continuing education requirements. Pharmacists shall complete continuing education for license renewal pursuant to the requirements of this rule. For purposes of this rule, "continuing education" means a structured educational activity that is applicable to the practice of pharmacy, that promotes problem solving and critical thinking, and that is designed or intended to support the continuing development of pharmacists to maintain and enhance their competence in the practice of pharmacy. Nothing in these rules precludes the board from requiring an applicant for renewal to submit to a relicensure examination.

2.12(1) Continuing education unit required. The nationally accepted measurement of continuing education is referred to as CEU (continuing education unit), and the board employs that measurement. Ten contact hours of approved continuing education are equivalent to one CEU.

a. The board will require 3.0 CEUs each renewal period except as provided in subrule 2.12(5) or rule 657—2.17(272C). For purposes of this rule, "renewal period" means the 27-month period commencing April 1 prior to the previous license expiration and ending June 30, the date of current license expiration.

b. A pharmacist who fails to complete the required CEUs within the renewal period shall be required to complete one and one-half times the number of delinquent CEUs prior to reactivation of the license.

c. CEUs that are used to satisfy the continuing education requirement for one renewal period shall not be used to satisfy the requirement for a subsequent renewal period.

d. Failure to receive a license renewal application or notice of license renewal shall not relieve the pharmacist of the responsibility of meeting continuing education requirements.

2.12(1) 2.12(2) Continuing education activity attendance completion. Continuing education activities that carry the seal of an Accreditation Council for Pharmacy Education (ACPE)-accredited provider will automatically qualify for continuing education credit. Attendance Successful completion and record of continuing education activities in CPE Monitor is mandated in order for a pharmacist to receive credit unless the activity is an ACPE-accredited correspondence course for ACPE-accredited provider continuing education activities.

a. Non-ACPE provider activity. A maximum of 1.3 CEUs (13 contact hours) of the total 3.0 CEUs of continuing education credits required pursuant to subrule 2.12(4) may be obtained through completion of non-ACPE provider activities if such activities are provided by an accredited health-professional continuing education provider, such as a continuing medical education (CME) provider, and if the activity content directly relates to the pharmacist's professional practice. Non-ACPE

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provider activity completion shall be recorded, evaluated, and reported pursuant to the provisions of rule 657—2.17(272C) regarding continuing professional development.

(1) The pharmacist is responsible for ensuring that the activity content directly relates to the pharmacist's professional practice.

(2) ~~In addition, if~~ If one or more non-ACPE provider activities are intended to fulfill the requirement in paragraph 2.12(4) "c," the pharmacist is responsible for ensuring the activity content relates to patient or medication safety.

(3) If the non-ACPE provider is not able to transmit the activity record to CPE Monitor, the provider shall provide to the pharmacist a statement of credit that indicates the pharmacist's participation in and successful completion of the continuing education activity. The statement of credit shall include all information identified in subrule 2.12(3), except for the pharmacist's CPE Monitor e-profile identification number.

b. Exemption for health-related graduate studies. A pharmacist who is continuing formal education in a health-related graduate programs program, including participation in a pharmacy residency program, may be exempted from meeting the continuing education requirements during the period of such enrollment or participation. As an alternative to requesting exemption from meeting the continuing education requirements, the pharmacist may complete a CPD portfolio pursuant to rule 657—2.17(272C).

(1) An applicant for this exemption shall petition the board, as soon as possible following enrollment in the qualifying graduate program or commencement of the pharmacy residency program and prior to completion of the qualifying program, on forms provided by the board office.

(2) At the discretion of the board, exemption during part-time or short-term enrollment in a health-related graduate program may be prorated for the actual period of such enrollment.

~~2.12(2) Continuing education unit required.~~ The nationally accepted measurement of continuing education is referred to as CEU (continuing education unit), and the board of pharmacy employs that measurement. Ten contact hours of approved continuing education are equivalent to one CEU. The board of pharmacy will require 3.0 CEUs each renewal period. For purposes of this rule, "renewal period" means the 27-month period commencing April 1 prior to the previous license expiration and ending June 30, the date of current license expiration. A pharmacist who fails to complete the required CEUs within the renewal period shall be required to complete one and one-half times the number of delinquent CEUs prior to reactivation of the license. CEUs that are used to satisfy the continuing education requirement for one renewal period shall not be used to satisfy the requirement for a subsequent renewal period.

2.12(3) Continuing education activity statement record of credit.

~~a.~~ An accredited ACPE-accredited provider will be required to make available to transmit to CPE Monitor information regarding an individual pharmacist a statement of credit that indicates pharmacist's participation in and successful completion of and participation in a continuing education activity. The statement of credit will carry record shall be accessible to the board and shall include the following information:

(1) a. Pharmacist's full name and CPE Monitor e-profile identification number.

(2) b. Number of contact hours or CEUs awarded for activity completion.

(3) c. Date of live activity or date of completion of home study activity.

(4) d. Name of accredited provider.

(5) e. Activity title and universal activity number.

~~b.~~ A pharmacist must retain statements of credit in the pharmacist's personal files for four years.

2.12(4) Continuing education activity topics. Each pharmacist is required to obtain continuing education by completing activities in the topics specified in this subrule.

a. Drug therapy. A minimum of 1.5 CEUs (15 contact hours) of the pharmacist's required 3.0 CEUs shall be in ACPE-accredited provider activities dealing with drug therapy. Activities qualifying for the drug therapy requirement will include the ACPE topic designator "01" or "02" ~~in the last two digits~~ followed by the letter "P" at the end of the universal activity number.

b. Pharmacy law. A minimum of 0.2 CEUs (2 contact hours) of the pharmacist's required 3.0 CEUs shall be in ACPE-accredited provider activities dealing with pharmacy law. Activities qualifying

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for the pharmacy law requirement will include the ACPE topic designator "03" ~~in the last two digits followed by the letter "P" at the end of the universal activity number.~~

c. Patient or medication safety. A minimum of 0.2 CEUs (2 contact hours) of the pharmacist's required 3.0 CEUs shall be in activities dealing with patient or medication safety. Activities completed to fulfill this requirement may be ACPE-accredited provider activities, in which case the ~~last two digits of the universal activity number will include end with the ACPE topic designator "05;" or followed by the letter "P."~~ A pharmacist may complete non-ACPE provider activities as provided in ~~subrule 2.12(1) paragraph 2.12(2)"a" to fulfill this topic requirement.~~

2.12(5) *New license holders licensed by examination.* After the initial license is issued by examination, the new license holder is exempt from meeting continuing education requirements for the first license renewal. However, if the licensee qualifies as a mandatory abuse reporter, the licensee shall not be exempt from mandatory training for identifying and reporting abuse pursuant to rule 657—2.16(235B,272C). Regardless of when the license is first issued, the new license holder will be required to obtain, prior to the second renewal, 30 contact hours (3.0 CEUs) of continuing education pursuant to subrules 2.12(1) through 2.12(4) or to complete a CPD portfolio pursuant to rule 657—2.17(272C).

2.12(6) *New license holders licensed by license transfer/reciprocity.* After the initial license is issued by license transfer, the new license holder will be required to obtain, prior to the first license renewal, 30 contact hours (3.0 CEUs) of continuing education credits pursuant to subrules 2.12(1) through 2.12(4) or to complete a CPD portfolio pursuant to rule 657—2.17(272C).

2.12(7) *Reporting continuing education credits.*

a. ~~A pharmacist shall submit on or with the renewal application form documentation that the continuing education requirements have been met. Documentation shall be in a format that includes the following:~~ provide or report to the board, in the format specified on or with the pharmacist license renewal application, evidence that the continuing education requirements have been met.

- ~~(1) The total number of credits accumulated for the renewal period;~~
- ~~(2) The individual activities completed, including activity title and universal activity number;~~
- ~~(3) The dates of completion;~~
- ~~(4) The credits awarded for each activity;~~
- ~~(5) The name of the provider of each activity; and~~
- ~~(6) Identification of the activities completed to comply with the drug therapy requirements in subrule 2.12(4).~~

b. The board may require a pharmacist to submit ~~the activity statements of credit that document or other documented evidence of successful completion of the activities included with or on the renewal application reported as fulfilling the continuing education requirements.~~

c. ~~Failure to receive the renewal application shall not relieve the pharmacist of the responsibility of meeting continuing education requirements.~~

2.12(8) *Relicensure examination.* ~~Nothing in these rules precludes the board from requiring an applicant for renewal to submit to a relicensure examination.~~

2.12(9) **2.12(8)** *Physical disability or illness.* The board may, in individual cases involving physical disability or illness, grant waivers of the minimum continuing education requirements or extensions of time within which to fulfill the same or make the required reports. No waiver or extension of time shall be granted unless written application is made and signed by the licensee and the licensee's physician. The board may grant waivers of the minimum continuing education requirements for physical disability or illness for any period of time not to exceed one renewal period. In the event that the physical disability or illness upon which a waiver has been granted continues beyond the period of the waiver, the licensee must reapply for an extension of the waiver. The board may, as a condition of any waiver granted, require the licensee to make up all or any portion of the waived continuing education requirements by any method prescribed by the board.

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ITEM 2. Amend rule 657—2.13(272C) as follows:

657—2.13(272C) Active and inactive license status.

2.13(1) Active license. Active license status applies to a pharmacist who has submitted the renewal application and fee and has met Iowa requirements for continuing education or has completed a CPD portfolio pursuant to rule 657—2.17(272C). Active license status also applies to a pharmacist who has submitted the renewal application and fee and who is a resident of another state, is licensed to practice pharmacy in that state, and has met the continuing education requirements of that state. A pharmacist who meets the continuing education requirements of another state shall provide documentation on the renewal application of the pharmacist's license status in that state. An Iowa licensee actively practicing in a state that does not require continuing education for license renewal shall be required to meet Iowa continuing education or CPD requirements.

2.13(2) Inactive license. Failure of a pharmacist to comply with the continuing education or CPD requirements during the renewal period will shall result in the issuance of a renewal card marked "inactive" upon submission of the renewal application and fee. Reactivation of an inactive pharmacist license shall be accomplished by the appropriate method described below. Internship, in each instance where internship is mentioned below, shall be in a pharmacy approved by the board. The pharmacist ~~will~~ may be required to obtain a pharmacist-intern registration, including payment of the appropriate registration fee, and be issued an intern registration certificate.

a. An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in any state or states which required continuing education during that five-year period shall submit proof of continued licensure in good standing in the state or states of such practice.

b. An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in a state which does not require continuing education shall submit proof of continued licensure in good standing in the state or states of such practice. The pharmacist shall also complete one of the following options:

- (1) Take and successfully pass the MPJE, Iowa Edition, as provided in subrule 2.1(1);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours); ~~or~~
- (3) Obtain one and one-half times the number of continuing education credits required under ~~2.12(2)~~ subrule 2.12(1) for each renewal period the pharmacist was inactive; ~~or~~
- (4) Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

c. An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy during the past five years, and whose license has been inactive for not more than five years, shall complete one of the following options:

- (1) Successfully pass all components of the licensure examination as required in rule 657—2.1(147,155A);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status; ~~or~~
- (3) Obtain one and one-half times the number of continuing education credits required under ~~2.12(2)~~ subrule 2.12(1) for each renewal period the pharmacist was inactive; ~~or~~
- (4) Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

d. An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy for more than five years shall petition the board for reactivation of the license to practice pharmacy under one or more of the following options:

- (1) Successfully pass all components of the licensure examination as required in rule 657—2.1(147,155A);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours); ~~or~~

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(3) Obtain one and one-half times the number of continuing education credits required under ~~2.12(2)~~ subrule 2.12(1) for each renewal period the pharmacist was inactive; or

(4) Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

ITEM 3. Adopt the following new rule 657—2.17(272C):

657—2.17(272C) Continuing professional development portfolio. A pharmacist may complete and submit with the pharmacist's license renewal a continuing professional development (CPD) portfolio to fulfill the continuing education requirements in rule 657—2.12(272C). For purposes of these rules, "CPD" means a self-directed, ongoing, systematic, and outcomes-focused approach to learning and professional development including active participation in learning activities that assist a pharmacist in developing and maintaining continuing competence in the practice of pharmacy, enhancing the pharmacist's professional practice, and supporting achievement of the pharmacist's career goals. Definitions and descriptions of the terms "continuing education," "CEU," and "renewal period" included in rule 657—2.12(272C) shall apply to those terms as used in this rule.

2.17(1) Declaration of intent. A pharmacist shall declare on or with the previous license renewal, or shall notify the board no later than January 1 of the year the pharmacist's license is scheduled for renewal, of the pharmacist's intent to complete a CPD portfolio for the next license renewal.

a. The pharmacist's declaration of intent shall be in writing. Oral declaration of intent to complete a CPD portfolio will not be accepted.

b. A declaration of intent may be delivered to the board office via e-mail, facsimile transmission, or alternate hard-copy delivery.

2.17(2) Prerequisite. A pharmacist, prior to submitting the pharmacist's initial CPD portfolio, shall complete an ACPE-accredited provider activity regarding the objectives and processes relating to CPD. Record of the pharmacist's participation in this prerequisite activity shall be included in the pharmacist's initial CPD portfolio.

2.17(3) CPD portfolio requirements. A pharmacist shall combine traditional continuing education activities with professional development activities. The pharmacist shall incorporate the record of completion and evaluation of any traditional continuing education activities into the CPD portfolio.

a. The pharmacist is responsible for ensuring that the activity content identified in the CPD portfolio directly relates to the pharmacist's professional practice and career goals.

b. The pharmacist is responsible for ensuring that the activities identified in the CPD portfolio comply with the continuing education topic requirements identified in subrules 2.12(4) and 2.17(4).

2.17(4) CPD portfolio content. In addition to the record of completion of the one-time prerequisite activity identified in subrule 2.17(2), a completed CPD portfolio shall include or identify the following:

a. A minimum of 30 documented learning outcomes in the form of completed learning statements. The learning statement form or format shall be provided by the board.

b. Documented learning outcomes shall include a minimum of two outcomes relating to patient or medication safety, two outcomes relating to pharmacy law, and 15 outcomes relating to drug therapy.

c. Documented learning outcomes shall include any number of continuing education activities that carry the seal of an ACPE-accredited provider. Successful completion and record of these continuing education activities in CPE Monitor as provided in subrule 2.12(2), in addition to the documented CPD learning outcomes, is required for the pharmacist to receive credit for these activities.

d. Documented learning outcomes shall include any continuing education activities provided by non-ACPE, accredited, health-professional continuing education providers pursuant to subrule 2.12(2).

2.17(5) CPD portfolio review. The board shall review or may contract for peer review of CPD portfolios submitted for pharmacist license renewal. The board shall respond to a submitting pharmacist

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with comments, suggestions, and recommendations regarding the pharmacist's CPD portfolio and processes.

[Filed 1/17/13, effective 3/13/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0596C

PHARMACY BOARD[657]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 124.301 and 147.76, the Board of Pharmacy hereby amends Chapter 13, "Sterile Compounding Practices," and Chapter 20, "Pharmacy Compounding Practices," Iowa Administrative Code.

The amendments change definitions in Chapters 13 and 20 to clarify the terms used. The amendments also change the format of references to rules throughout by adding the Board's agency identification number to the references. Record requirements for sterile compounded drug products are added as new rule 657—13.8(155A), and the use of the same biological safety cabinet (BSC) or compounding aseptic isolator (CAI) for the compounding of nonhazardous sterile or nonsterile compounded drug products and for the compounding of hazardous drugs is prohibited unless the BSC or CAI is appropriately decontaminated between uses. The amendments reorganize subrule 20.3(4) into paragraphs addressing specific sales and advertising issues and add a paragraph authorizing the compounding of drug products and placebos for dispensing to subjects in an approved university or college research project. The amendments provide that a compounding production record is not required when personnel mix or reconstitute a drug according to the product's labeling or the manufacturer's directions and clarify that the record of an individual involved in any step of the compounding or verification process shall consist of the initials or other unique identification of that individual.

Requests for waiver or variance of the discretionary provisions of these rules will be considered pursuant to 657—Chapter 34.

Notice of Intended Action was published in the October 3, 2012, Iowa Administrative Bulletin as **ARC 0374C**. The Board received written comments regarding the proposed amendments from two hospital pharmacists engaged in the preparation of compounded drug products. One commenter suggested that the proposed amendments created ambiguity regarding the definition and identification of practices that constitute drug compounding and the instances when the mixing of products is not considered compounding. The other commenter felt that the proposed definition of "compounding" eliminated much of the current confusion created by conflicting definitions between the two chapters but suggested that the definitions should be expanded to address the transfer of a reconstituted medication into another sterile fluid. The adopted amendments differ from those published under Notice. In Item 2, the proposed amendment to the definition of "compounding" in rule 657—13.2(124,126,155A) has not been adopted to allow for further consideration.

The amendments were approved during the January 16, 2013, meeting of the Board of Pharmacy.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 124.306, 124.308, 126.9, 126.10, 155A.2, 155A.4, 155A.13, 155A.13A, 155A.28, 155A.33, and 155A.35.

These amendments will become effective on March 13, 2013.

The following amendments are adopted.

ITEM 1. Amend rule 657—13.1(124,126,155A) as follows:

657—13.1(124,126,155A) Purpose and scope. These rules establish standards and procedures for the preparation, labeling, and distribution of sterile preparations by licensed pharmacies pursuant to a practitioner's order or prescription; for sterile product quality and characteristics; for personnel

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training, environmental quality, and equipment standards; and for pharmaceutical care. Sterile compounding differs from nonsterile compounding primarily by requiring the maintenance of sterility when preparations are compounded exclusively with sterile ingredients and components and by requiring the achievement of sterility when preparations are compounded with nonsterile ingredients and components. The standards and procedures outlined in this chapter apply to pharmacy practice when a preparation:

1. Is prepared according to the manufacturer's labeled instructions and requires other manipulations that expose the original contents to potential contamination;

2. Contains nonsterile ingredients or employs nonsterile components or devices that must be sterilized before administration; or

3. Is a biologic, diagnostic, drug, or nutrient that possesses characteristics of either "1" or "2" above and includes, but is not limited to, the following preparations that are required to be sterile when they are administered to patients: ~~baths and soaks for live organs and tissues, into patient body cavities, central nervous and vascular systems, eyes, and joints, and when used as baths for live organs and tissues, such as injections (e.g., colloidal dispersions, emulsions, solutions, and suspensions), aqueous bronchial and nasal inhalations, irrigations for wounds and body cavities, ophthalmic drops and ointments, and tissue implants.~~

Standards and safe practices for the compounding of radioactive preparations are identified in 657—Chapter 16.

ITEM 2. Amend rule **657—13.2(124,126,155A)**, definitions of "High-risk preparation," "Low-risk preparation" and "Medium-risk preparation," as follows:

"*High-risk preparation*" means a sterile preparation that is compounded from nonsterile ingredients; that is compounded with nonsterile components, containers, or equipment and requires terminal sterilization; or that meets the conditions of rule 657—13.13(155A).

"*Low-risk preparation*" means a sterile preparation that is compounded with sterile equipment, sterile ingredients, and sterile contact surfaces or that meets the conditions of rule 657—13.11(155A).

"*Medium-risk preparation*" means a sterile preparation that is compounded with sterile equipment, sterile ingredients, and sterile contact surfaces and involves complex or numerous manipulations of a sterile product or that meets the conditions of rule 657—13.12(155A).

ITEM 3. Adopt the following **new** definition of "Nasal inhalation" in rule **657—13.2(124,126,155A)**:

"*Nasal inhalation*" means a drug product or preparation, including the delivery device if applicable, whose intended site of deposition is the respiratory tract or the nasal or pharyngeal region. Nasal inhalation does not include a topical nasal spray or irrigation that is deposited primarily in the nasal passages.

ITEM 4. Amend subrule 13.6(1) as follows:

13.6(1) *Quality assurance program.* The policy and procedure manual shall include a quality assurance program pursuant to rule 657—13.31(155A).

ITEM 5. Amend subrule 13.6(2) as follows:

13.6(2) *Sampling.* The policy and procedure manual shall include procedures that require sampling of a preparation as provided in rule 657—13.29(126,155A) or if microbial contamination is suspected.

ITEM 6. Adopt the following **new** rule 657—13.8(155A):

657—13.8(155A) Record requirements.

13.8(1) *Production record.* A production record shall be prepared and kept for each drug product compounded for an individual patient. A production record is not required when mixing or reconstituting a drug according to the product's labeling or the manufacturer's directions. The record shall include the following information:

a. Production date;

b. List of ingredients and quantity of each ingredient used;

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- c. Initials or unique identification of each person involved in each of the compounding steps;
- d. Initials or unique identification of each pharmacist verifying each of the compounding steps;
- e. Internal control or prescription number and, if the prescription is filled using a product compounded in bulk pursuant to rule 657—20.11(126), the internal control number assigned to the batch and recorded in the batch production record.

13.8(2) *Batch master formula record.* Pursuant to the provisions of 657—subrule 20.3(3), pharmacies may compound drugs in bulk quantities for subsequent prescription labeling and dispensing. For each drug product compounded in bulk quantity, a master formula record containing the following information shall be prepared:

- a. Name of the product;
- b. Specimen or copy of label;
- c. List of ingredients and quantities;
- d. Description of container used;
- e. Compounding instructions, procedures and specifications.

13.8(3) *Batch production record.* For each batch of drug product compounded, a production record containing the following information shall be prepared and maintained:

- a. The information from the master formula record;
- b. Records of each step in the compounding process including:
 - (1) Preparation date;
 - (2) Identification of ingredients (including lot numbers);
 - (3) Quantities of ingredients used;
 - (4) Initials or unique identification of person completing each step;
 - (5) Initials or unique identification of pharmacist verifying each step;
- c. Expiration/beyond-use date;
- d. Internal control number;
- e. Total yield.

ITEM 7. Amend rule 657—13.10(126,155A) as follows:

657—13.10(126,155A) *Microbial contamination risk levels.* Preparations shall be assigned an appropriate risk level—low, medium or high—according to the corresponding probability of contaminating a preparation with microbial contamination such as microbial organisms, spores, and endotoxins, and chemical and physical contamination such as foreign chemicals and physical matter. The characteristics described in rules 657—13.11(155A), 657—13.12(155A), and 657—13.13(155A) are intended as guides to the diligence required in compounding at each risk level.

ITEM 8. Amend rule 657—13.14(155A) as follows:

657—13.14(155A) *Immediate-use preparations.* The immediate-use provisions of this rule are intended only for those situations where there is a need for emergency or immediate administration of a sterile preparation. Such situations may include cardiopulmonary resuscitation, emergency room treatment, preparation of diagnostic agents, or critical therapy where the compounding of the preparation under low-risk level conditions would subject the patient to additional risk due to delays in therapy. Immediate-use preparations are not intended for storage for anticipated needs or for batch compounding. Medium-risk and high-risk preparations shall not be compounded as immediate-use preparations. Immediate-use preparations are exempt from the provisions of rule 657—13.11(155A) for low-risk preparations only when all of the following criteria are met:

- 1. to 6. No change.

ITEM 9. Amend subrule 13.20(3) as follows:

13.20(3) *Preparation area.* All hazardous drugs shall be compounded in a vertical flow Class II or Class III biological safety cabinet or in a compounding aseptic isolator containment and control device with biohazard control capabilities. A BSC or CAI used for the compounding of hazardous drugs shall not be used for the compounding of nonhazardous sterile or nonsterile compounded products unless

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the BSC or CAI is decontaminated in compliance with industry standards appropriate for inactivating hazardous drugs.

a. and b. No change.

ITEM 10. Amend subrule 13.20(8) as follows:

13.20(8) Spills of hazardous drugs. Written procedures for handling both major and minor spills of hazardous drugs shall be developed, maintained, implemented, and adhered to. The procedures shall be maintained with the policies and procedures required in rule 657—13.6(155A).

ITEM 11. Amend paragraph **13.31(2)“c”** as follows:

c. Reviewing documented patient or caregiver education and training required pursuant to rule 657—13.32(155A).

ITEM 12. Amend rule 657—20.3(124,126,155A) as follows:

657—20.3(124,126,155A) General requirements.

20.3(1) No change.

20.3(2) Substances and components. Pharmacists shall receive, store, and use bulk drug substances manufactured by an establishment that is registered with the FDA under the Federal Food, Drug, and Cosmetic Act and that, if requested, will provide a valid certificate of analysis for each drug product. Certificates of analysis shall be maintained pursuant to rule 657—20.12(124,126,155A). Bulk drug substances to be used in compounding drugs:

a. to d. No change.

20.3(3) Prescriber/patient/pharmacist relationship. A prescription for a compounded drug shall be authorized by the prescriber for a specific patient. Prescriptions for all products compounded at the pharmacy shall be maintained on file at the pharmacy as required by Iowa law. Pharmacists may compound drugs prior to receiving a valid prescription based on a history of receiving valid prescriptions generated solely within an established pharmacist/patient/prescriber relationship. Compounding based on a prescription history is bulk compounding and shall comply with the requirements of rule 657—20.11(126).

20.3(4) Advertising and resale of compounded drug products. The sale of compounded drug products to other pharmacies or to prescribers, except as provided in this subrule, is considered manufacturing.

a. Sale to practitioner for office use. ~~Pharmacists~~ A pharmacist shall not offer compounded drug products to other licensed persons or commercial entities for subsequent resale except in the course of professional practice for a practitioner to administer to an individual patient.

b. Sale to hospital pharmacy for administration to a specific patient. A pharmacy may sell to a hospital pharmacy a compounded drug product prepared pursuant to a prescriber's authorization for administration to a specific patient. The label affixed to the compounded drug product shall identify the pharmacy that compounded the product as the dispensing pharmacy. The original prescription drug order shall be maintained by the dispensing pharmacy. These rules shall not prohibit the hospital pharmacy from billing the patient or the patient's fiscal agent for a compounded product prepared for the patient and purchased by the hospital pharmacy pursuant to this subrule.

c. Advertising compounding services. ~~Compounding pharmacies or pharmacists~~ A compounding pharmacy or pharmacist may advertise or otherwise promote the fact that they provide the pharmacy or pharmacist provides prescription drug compounding services. ~~Compounding pharmacies or pharmacists~~ A compounding pharmacy or pharmacist shall not make a claim, assertion, or inference of professional superiority in the compounding of drug products that cannot be substantiated. All advertisements shall meet the requirements contained in rule 657—8.12(126,147).

d. Central fill or processing of compounded drug products. Nothing in these rules shall prohibit the centralized filling or processing of a prescription drug order for a compounded drug product by a central fill or processing pharmacy on behalf of an originating pharmacy as provided in 657—Chapter 18.

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e. Compounding for research. A compounding pharmacy may compound drug products and placebos for dispensing to subjects involved in an approved blinded university or college research project. Drug products and placebos compounded for this purpose shall be labeled as provided in the research protocol and may be dispensed directly to patients, delivered to another pharmacy for delivery to patients, or delivered to the researcher for delivery to patients. Provisions of subrule 20.3(1) prohibiting the compounding of commercially available products shall not apply to the compounding of products and placebos for research pursuant to this paragraph.

20.3(5) No change.

ITEM 13. Amend subrule 20.6(2) as follows:

20.6(2) Radiopharmaceuticals. If radiopharmaceuticals are being compounded, the requirements of 657—Chapter 16 and rule 657—13.20(124,155A) shall be met.

ITEM 14. Amend subrule 20.10(3) as follows:

20.10(3) Record. A production record shall be prepared and kept for each drug product compounded for an individual patient. A production record is not required when a drug is mixed or reconstituted according to the product's labeling or the manufacturer's directions. The record shall include the following information:

- a. Production date;
- b. List of ingredients and quantity of each ingredient used;
- c. Initials or unique identification of each person involved in each of the compounding steps;
- d. Initials or unique identification of each pharmacist verifying each of the compounding steps;
- e. Internal control or prescription number and, if the prescription is filled using a product compounded in bulk pursuant to rule 657—20.11(126), the internal control number assigned to the batch and recorded in the batch production record.

ITEM 15. Amend subrule 20.10(8) as follows:

20.10(8) Labeling and control of excess products. When a quantity of a compounded drug product is prepared in excess of that to be initially dispensed, the excess product shall be labeled, stored, and accounted for pursuant to rule 657—20.11(126).

ITEM 16. Amend rule 657—20.11(126) as follows:

657—20.11(126) Bulk compounding.

20.11(1) No change.

20.11(2) Production record. For each batch of drug product compounded, a production record containing the following information shall be prepared and maintained:

- a. The information from the master formula record;
- b. Records of each step in the compounding process including:
 - (1) Preparation date;
 - (2) Identification of ingredients (including lot numbers);
 - (3) Quantities of ingredients used;
 - (4) Initials or unique identification of person completing each step;
 - (5) Initials or unique identification of pharmacist verifying each step;
- c. Expiration/beyond-use date;
- d. Internal control number;
- e. Total yield.

20.11(3) No change.

[Filed 1/17/13, effective 3/13/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0577C**PUBLIC HEALTH DEPARTMENT[641]****Adopted and Filed**

Pursuant to the authority of Iowa Code sections 136C.3 and 136C.10, the Department of Public Health hereby amends Chapter 38, "General Provisions for Radiation Machines and Radioactive Materials," and Chapter 41, "Safety Requirements for the Use of Radiation Machines and Certain Uses of Radioactive Materials," and rescinds Chapter 42, "Minimum Certification Standards for Diagnostic Radiographers, Nuclear Medicine Technologists, and Radiation Therapists," and adopts new Chapter 42, "Permit to Operate Ionizing Radiation Producing Machines or Administer Radioactive Materials," Iowa Administrative Code.

The rules in Chapter 42 provide the certification standards for individuals who operate ionizing radiation machines or use radioactive materials. These amendments simplify the format of the chapter, clarify the language and move some items from other chapters to make Chapter 42 self-contained. The following paragraphs summarize the changes:

1. Paragraphs from Chapter 38 are rescinded and incorporated into Chapter 42 in order to make Chapter 42 self-contained.

2. Paragraphs in Chapter 41 are amended to remove language requiring the posting of the permit. Individuals will be required to make the permits available at each facility. This change is to prevent public access to last names of permit holders.

3. The requirements and process for obtaining a permit are clearly outlined for each classification.

4. Procedures for renewing permits and handling expired permits are clarified.

5. Continuing education requirements for radiologist assistants are made consistent with the national standards of the American Registry of Radiologic Technologists (ARRT).

6. Provisions for listing two modalities on one permit are added.

7. Continuing education requirements for podiatric X-ray equipment operators are increased from 2.0 hours to 4.0 hours to ensure maintenance of competencies. The topics of continuing education activities that will be accepted have been expanded for all permit holders to allow more variety and make permits easier to obtain.

8. A requirement for a permit for an individual who performs only bone densitometry radiography is added to ensure uniform radiation safety training. An individual who holds a general radiologic technologist or a limited radiologic technologist permit under this chapter will not need to apply for this permit because the radiation safety training is already completed.

9. Two permit classifications, limited in-hospital radiologic technologist and limited nuclear medicine technologist, and one limited permit category, paranasal sinus, are closed to new applicants. These permits were originally issued to meet special needs and are no longer necessary.

10. On March 13, 2013, the effective date of these amendments, the Department will no longer approve continuing education credit hours. All credit hours must be approved by other approval bodies accepted by the Department. This change will streamline the permit process and allow more options for continuing education. The Department has assessed the costs of administering the continuing education approval process and reviewed the practices of other licensing agencies and found that it is common to defer continuing education approval to the private sector.

11. All current continuing education credit hour approvals currently approved by the Department will no longer be eligible for renewal and will expire on the stated expiration date for the activity or January 1, 2015, whichever comes first.

12. Continuing education for all modalities will no longer be classification-specific. Permit holders may complete continuing education hours from any classification. This change is consistent with national standards of the ARRT and will allow permit holders more flexibility in choosing continuing education.

13. Specific requirements for the CT subcategory are removed. CT is included as a part of the general radiologic technologist permit. This change is also consistent with national standards of the ARRT.

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14. The continuing education requirement for 1.0 hour in radiation protection for diagnostic technologists and radiation therapists is removed. The requirement for 1.0 hour each for radiation protection and quality assurance for nuclear medicine technologists is also removed. This change is consistent with national standards of the ARRT.

15. Requirements for curriculum and clinical competencies for formal education are clarified for limited diagnostic technologists. The revised requirements will help provide more uniform training.

16. The term “radiographer” is changed to “radiologic technologist” or “technologist” throughout. This change is consistent with ARRT language.

These rules are subject to waiver pursuant to the Department’s waiver provision contained at 641—38.3(136C). For this reason, the Department has not provided a specific provision for waiver of these particular rules.

Notice of Intended Action was published in the October 3, 2012, Iowa Administrative Bulletin as **ARC 0381C**. Sixteen individuals attended the public hearing on October 23, 2012, and 14 of those attending provided oral comments. Sixteen submissions of written comments were received. All comments were reviewed, and changes were incorporated as appropriate. Comments received addressed the following subject areas:

- The overall proposed rules and comment process.
- Fees, although fee increases are not a part of the amendments.
- The removal of the requirement for permit holders to obtain one hour of continuing education specific to radiation protection.
- The removal of the requirement that permit holders obtain continuing education specific to their permit modality or classification.
- The ARRT or NMTCB renewal documentation allowed for renewal of an IDPH permit.
- The discontinuation of the IDPH continuing education approval program.
- The pediatric designation for limited radiologic technologists.
- The amendments to the competency requirements for the formal education for limited radiologic technologists.
- The closed permit categories of limited in-hospital technologist, limited nuclear medicine technologist and the limited paranasal sinus category.
- The potential impacts of these amendments on radiologic technologists performing mammography examinations.
- How these rules will impact which permit holders may perform PET/SPECT/CT and diagnostic CT examinations.
- The title for limited radiologic technologist permit.
- The age at which limited radiologic technologist permit holders must obtain additional education in order to radiograph pediatric patients.
- The removal of the definition of “supervision.”
- The exemptions section.
- The approval entities allowed for continuing education and a request that podiatry-specific entities be allowed.
- The need for additional time required for schools to implement changes to formal education requirements into their curriculum.
- Rule wording or references that needed revision or inclusion.

As a result of the comments received on the proposed amendments and additional internal review, the Department made the following changes to the amendments published under Notice of Intended Action:

1. Added a new Item 5 to reflect the change in permit posting requirements for nuclear medicine and radiation therapy permit holders. As a result, Noticed Items 5 and 6 were renumbered as Items 6 and 7.
2. In Item 4, added the words “and holds a current permit to practice as a general radiologic technologist as defined under the provisions of 641—Chapter 42” to 41.1(11)“d”(4)“1.”
3. In rule 641—42.1(136C), introductory paragraph, changed “training” to “formal education.”

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4. In paragraph 42.9(1)“c,” introductory paragraph, changed “projections” to “areas.” The “areas” listed in subparagraphs 42.9(1)“c”(1) to (4) have several acceptable projections as taught in the curriculum.

5. In paragraph 42.9(1)“d” regarding the shoulder category, added a new subparagraph 42.9(1)“d”(4) and renumbered Noticed subparagraph 42.9(1)“d”(4) as (5). The new subparagraph reads as follows:
“(4) Scapular Y lateral.”

6. In paragraph 42.9(1)“e,” second sentence, changed “categories of either chest or extremities” to “minimum categories of chest or extremities” and changed “be granted this category” to “qualify for pediatric radiography.” Also in paragraph 42.9(1)“e,” transposed the words “are prohibited” and “by limited radiologic technologists” in the last sentence and added the sentence “This designation allows permit holders to perform pediatric radiography within the permit classifications listed on their permit only.”

7. In paragraph 41.9(2)“d,” added the words “chest or” before the word “extremity” in the second sentence.

8. In subrule 42.18(1), added “, or” to the end of the subrule.

9. In paragraph 42.18(2)“a,” added the phrase “name of the approving organization” to document requirements of acceptable proof.

10. In rule 641—42.18(136C), added new subrule 42.18(3) to address podiatric X-ray equipment operator permit holders.

11. In subrule 42.31(1) regarding limited radiologic technologists, changed the words “consist of individual training” to “be offered individually” for clarity.

12. In subparagraphs 42.31(2)“a”(3), 42.31(2)“b”(4), 42.32(1)“a”(3), 42.32(1)“b”(5), 42.33(1)“a”(2) and 42.33(1)“b”(4), changed the word “membership” to “registration” to be consistent with accepted terminology.

13. In subparagraph 42.31(2)“a”(3), corrected a typographical error by changing the word “last” to “least.”

14. In paragraph 42.31(2)“e,” changed the table as follows:

- The heading of the third column was changed from “Clinical practice hours” to “Clinical practice projections”;
- In the fourth column, “each projection” was changed to “any projection” wherever it appeared in that column; and
- The last row of the table pertaining to training for current permit holders to add a category was removed and the provision added as new subparagraph 42.31(2)“e”(3). New subparagraph 42.31(2)“e”(3) reads as follows:

“(3) Current permit holders completing formal education to add a category do not need to repeat the core curriculum.”

In addition, nonsubstantive changes have been made in 42.10(1)“e”(2), 42.32(1)“a”(3) and 42.33(1)“e” for consistency or clarification.

The State Board of Health adopted these amendments on January 9, 2013.

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code sections 136C.3, 136C.4, 136C.5, 136C.10, and 136C.14.

These amendments will become effective on March 13, 2013.

The following amendments are adopted.

ITEM 1. Rescind and reserve subrule **38.8(6)**.

ITEM 2. Amend numbered paragraph **41.1(3)“a”(2)“1”** as follows:

1. Operators in medical facilities shall meet the requirements of 641—Chapter 42, as applicable, and ~~have a current permit to practice in diagnostic radiography. The permit to practice shall be posted in the immediate vicinity of the general work area and visible to the public shall make the permit available at the individual’s place of employment. If the permit holder works at more than one facility, a duplicate of the permit shall be kept at each facility.~~

PUBLIC HEALTH DEPARTMENT[641](cont'd)

ITEM 3. Rescind and reserve paragraph **41.1(9)“c.”**

ITEM 4. Amend numbered paragraph **41.1(11)“d”(4)“1”** as follows:

1. The CT X-ray system shall not be operated except by a licensed practitioner or an individual who has been specifically trained in its operation ~~in accordance with 641—subrule 42.2(9) and holds a current permit to practice as a general radiologic technologist as defined under the provisions of 641—Chapter 42.~~

ITEM 5. Amend subparagraph **41.2(11)“a”(5)** as follows:

(5) Require that only those individuals certified and issued a current permit to practice in accordance with 641—Chapter 42 as a nuclear medicine technologist or a radiation therapist, as applicable, or an Iowa-licensed physician and designated by the authorized user, shall be permitted to administer radionuclides (sealed sources only for radiation therapists) or radiation to patients or human research subjects. For a nuclear medicine technologist or a radiation therapist, the individual’s permit to practice shall be ~~posted in the immediate vicinity of the general work area and be visible to the public made available at the individual’s place of employment.~~ If the permit holder works at more than one facility, a duplicate of the permit shall be kept at each facility.

ITEM 6. Amend subrule 41.3(7) as follows:

41.3(7) Qualifications of operators.

~~a.~~ Individuals who will be operating a therapeutic radiation machine for medical use shall be adequately instructed in the safe operating procedures, ~~be competent in the safe use of the equipment in accordance with 641—Chapter 42 as applicable,~~ and hold a current permit to practice in radiation therapy as a radiation therapist under the provisions of 641—Chapter 42.

~~b.~~ ~~Each operator’s permit to practice under 641—Chapter 42 shall be posted in the immediate vicinity of the general work area and visible to the public.~~

ITEM 7. Rescind 641—Chapter 42 and adopt the following **new** chapter in lieu thereof:

CHAPTER 42

PERMIT TO OPERATE IONIZING RADIATION PRODUCING MACHINES OR ADMINISTER RADIOACTIVE MATERIALS

641—42.1(136C) Purpose. The purpose of this chapter is to specify the permit requirements of individuals who operate or use ionizing radiation producing machines or administer radioactive materials on or to human patients or human research subjects for diagnostic or therapeutic purposes. This chapter establishes minimum formal education standards and examination, continuing education, and disciplinary procedures.

641—42.2(136C) Definitions.

“*ARRT*” means the American Registry of Radiologic Technologists.

“*Authorized user*” means an Iowa-licensed physician identified on a specific radioactive materials license or a license of broad scope as defined in 641—subrule 41.2(2).

“*Bone densitometry*” means the art and science of applying ionizing radiation to the human body using a dual energy X-ray absorptiometry unit for the sole purpose of measuring bone density.

“*Category*” defines specific duties allowed in the limited radiologic technologist permit classification.

“*Classification*” means a specific class of permit that allows the permit holder to perform the duties specified for that permit class.

“*Continuing education activity*” means a learning activity that is recognized as continuing education by the ARRT or NMTCB.

“*Department*” means the Iowa department of public health.

“*Expiration date*” means 11:59 p.m. on the stated date.

“*Formal education*” means a course of classroom and clinical instruction which meets the training standards set by the department.

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“Ionizing radiation producing machine” or *“radiation machine”* means an assemblage of components for the controlled production of X-rays. An ionizing radiation producing machine includes minimally an X-ray high-voltage generator, an X-ray control, a tube housing assembly, a beam-limiting device, and the necessary supporting structures. Additional components which function with the system are considered integral parts of the system.

“NMTCB” means Nuclear Medicine Technology Certification Board.

“Nuclear medicine procedure” means any procedure utilizing radiopharmaceuticals for diagnosis or treatment of disease in human beings and any duties performed by the technologist during sealed source procedures, and includes, but is not limited to:

1. Administration of any radiopharmaceutical to human beings for diagnostic purposes.
2. Administration of radioactive material to human beings for therapeutic purposes.
3. Use of radioactive material for diagnostic purposes involving transmission or excitation.
4. Quality control and quality assurance.

“Nuclear medicine technologist” means an individual who performs nuclear medicine procedures while under the supervision of an authorized user. The classifications are as follows:

1. “General nuclear medicine technologist” performs any nuclear medicine procedures.
2. “Limited nuclear medicine technologist” performs nuclear medicine procedures only as approved by the department at the time the initial permit was issued.

“Permit” means the document issued to an individual by the department when the individual has met the requirements of this chapter. This document authorizes the individual to perform the duties allowed for the classification of permit issued.

“Radiation therapist” means an individual who performs radiation therapy under the supervision of a radiation oncologist licensed in Iowa.

“Radiation therapy” means the science and art of performing simulation radiography or applying ionizing radiation emitted from X-ray machines, particle accelerators, or radioactive materials in the form of sealed sources to human beings for therapeutic purposes.

“Radiography” means a technique for generating and recording an X-ray pattern for the purpose of providing the user with an image(s) during or after termination of the exposure.

“Radiologic technologist” means an individual, excluding X-ray equipment operators, who performs radiography of the human body as ordered by an individual authorized by Iowa law to order radiography. The classifications are as follows:

1. “General radiologic technologist” performs radiography of any part of the human body.
2. “Limited radiologic technologist” performs radiography for the chest, spine, extremities, shoulder or pediatrics, excluding CT and fluoroscopy.
3. “Limited in-hospital radiologic technologist” performs radiography of any part of the human body as approved by the department at the time the initial permit was issued.

“Radiologist assistant” means an advanced-level radiologic technologist who has completed the necessary requirements in order to perform procedures as outlined in ARRT guidance while under supervision of a radiologist.

“Student” means an individual enrolled in and participating in formal education.

“Therapeutic” means a medical treatment using radiation for therapy purposes.

“X-ray equipment operator” means an individual performing radiography of the human body using dedicated equipment as ordered by an individual authorized by Iowa law to order radiography. These individuals do not qualify for a permit in any other classification. The classifications are as follows:

1. “Podiatric X-ray equipment operator” performs radiography of only the foot and ankle using dedicated podiatric equipment. Studies using CT, fluoroscopy, or nondedicated equipment are prohibited.
2. “Bone densitometry equipment operator” performs bone densitometry using only dual energy X-ray absorptiometry equipment. Studies using CT, fluoroscopy, or nondedicated equipment are prohibited.

641—42.3(136C) Exemptions.

42.3(1) The following are exempt from obtaining a permit as required by this chapter:

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- a. A licensed physician.
- b. A licensed physician's assistant.
- c. A licensed chiropractor.
- d. A licensed dentist.
- e. A licensed dental hygienist.
- f. A licensed podiatrist.
- g. An individual certified by the dental board in dental radiography.
- h. A student as a part of the student's formal education.

42.3(2) The department may, upon application or upon its own initiative, grant such exemptions from the requirements of this chapter as it determines are authorized by law and will not result in undue hazard to public health and safety. Application for exemptions should be made in accordance with 641—Chapter 178.

PERMIT APPLICATION AND RENEWAL

641—42.4(136C) Permit application and renewal. An individual shall not operate ionizing radiation producing machines or administer radioactive materials for diagnostic or therapeutic purposes unless the individual possesses a current Iowa permit in the individual's classification of practice.

641—42.5(136C) Permit to practice as a general radiologic technologist.

42.5(1) An individual applying for an initial permit shall:

- a. Be at least 18 years of age.
- b. Submit the appropriate completed application.
- c. Submit a nonrefundable \$60 application fee.
- d. Submit proof of a passing score on the ARRT general radiography examination.

42.5(2) An individual renewing a current permit shall:

- a. Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.
- b. Report 24.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

42.5(3) An individual reinstating an expired permit shall submit the following:

a. Application to reinstate and nonrefundable \$60 application fee. If the permit is expired six months or more, all previous exemptions from this chapter are no longer valid and the individual is subject to all requirements of subrule 42.5(1).

b. Any continuing education hours due at time of renewal. If the permit is expired more than one year past the expiration date, 24.0 hours of continuing education obtained within the previous 24 months must be submitted.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

641—42.6(136C) Permit to practice as a general nuclear medicine technologist.

42.6(1) An individual applying for an initial permit shall:

- a. Be at least 18 years of age.
- b. Submit the appropriate completed application.
- c. Submit a nonrefundable \$60 application fee.
- d. Submit proof of a passing score on ARRT's nuclear medicine examination or the NMTCB nuclear medicine examination.

42.6(2) An individual renewing a current permit shall:

- a. Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.
- b. Report 24.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

42.6(3) An individual reinstating an expired permit shall submit the following:

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a. Application to reinstate and nonrefundable \$60 application fee. If the permit is expired six months or more, all previous exemptions from this chapter are no longer valid and the individual is subject to all requirements of subrule 42.6(1).

b. Any continuing education hours due at time of renewal. If the permit is expired more than one year past the expiration date, 24.0 hours of continuing education obtained within the previous 24 months must be submitted.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

641—42.7(136C) Permit to practice as a radiation therapist.

42.7(1) An individual applying for an initial permit shall:

- a.* Be at least 18 years of age.
- b.* Submit the appropriate completed application.
- c.* Submit a nonrefundable \$60 application fee.
- d.* Submit proof of a passing score on the ARRT's radiation therapy examination.

42.7(2) An individual renewing a current permit shall:

- a.* Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.
- b.* Report 24.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

42.7(3) An individual reinstating an expired permit shall submit the following:

a. Application to reinstate and nonrefundable \$60 application fee. If the permit is expired six months or more, all previous exemptions from this chapter are no longer valid and the individual is subject to all requirements of subrule 42.7(1).

b. Any continuing education hours due at time of renewal. If the permit is expired more than one year past the expiration date, 24.0 hours of continuing education obtained within the previous 24 months must be submitted.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

641—42.8(136C) Permit to practice as a radiologist assistant.

42.8(1) An individual applying for an initial permit shall:

- a.* Submit the appropriate completed application.
- b.* Submit a nonrefundable \$60 application fee.
- c.* Submit proof of completion of formal education for a radiologist assistant.
- d.* Submit proof of one year of experience as a general radiologic technologist.
- e.* Submit proof of passing score on the ARRT radiologist assistant examination or another examination that is recognized by the department.

42.8(2) An individual renewing a current permit shall:

- a.* Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.
- b.* Report 50.0 hours of continuing education obtained within the biennium indicated on the individual's permit. Radiologist assistant permit holders must obtain at least one-half of the required continuing education in subject areas specific to radiography. The remainder may be earned as physician credit hours.

42.8(3) An individual reinstating an expired permit shall submit the following:

a. Application to reinstate and nonrefundable \$60 application fee. If the permit is expired six months or more, all previous exemptions from this chapter are no longer valid and the individual is subject to all requirements of subrule 42.8(1).

b. Any continuing education hours due at time of renewal. If the permit is expired more than one year past the expiration date, 50.0 hours of continuing education obtained within the previous 24 months must be submitted.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

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641—42.9(136C) Permit to practice as a limited radiologic technologist with categories of chest, spine, extremities, shoulder, pediatric. An individual with a limited radiologic technologist permit shall perform radiography only within the scope of the category(ies) in which the permit is issued.

42.9(1) The scope of each category is defined as follows:

a. “Chest” allows the permit holder to perform radiography of the lung fields including the cardiac shadow, as taught in the limited radiography formal education standards. Chest radiograph techniques shall not be manipulated for the evaluation of the shoulder, clavicle, scapula, ribs, thoracic spine and sternum. Limited radiologic technologists who have completed the appropriate formal education after January 1, 2009, may perform lateral decubitus chest views.

b. “Extremities” allows the permit holder to perform radiography for body parts from:

(1) The distal phalanges of the foot to the head of the femur, including its articulation with the pelvic girdle. True hip radiographs are prohibited.

(2) The distal phalanges of the hand to the head of the humerus. These projections may include the acromioclavicular or glenoid-humeral areas. The radiograph shall not include any of the views in the shoulder category unless the individual holds a limited radiologic technologist permit that includes the shoulder category.

c. “Spine” allows the permit holder to perform radiography of the spine in the approved areas only. Approved areas and limitations are described as:

(1) Cervical vertebrae.

(2) Thoracic (dorsal) vertebrae.

(3) Lumbar vertebrae to include the articulations with the sacrum and coccyx and the sacral articulation with the pelvic girdle. True pelvis radiographs or other projections performed with the image receptor positioned perpendicular to the long axis of the torso are prohibited under this category.

(4) All projections shall be performed as taught in the limited radiologic technologist formal education standards.

d. “Shoulder” allows the permit holder to perform radiography of the shoulder in the approved projections only. Approved projections and limitations are described as:

(1) AP internal and external rotation.

(2) AP neutral.

(3) Transthoracic lateral views.

(4) Scapular “Y” lateral.

(5) The image may not include the proximal end of the clavicle on any AP projection. All other shoulder views are prohibited. The permit holder must hold a limited radiologic technologist permit with a category of either chest or extremity in order to be granted the shoulder category.

e. “Pediatric” allows the permit holder to perform radiography of either chest or extremities or both as defined in paragraphs 42.9(1) “*a*” and “*b*” above for patients aged 36 months and under. The permit holder must hold a limited radiologic technologist permit with the minimum categories of chest or extremities or both in order to qualify for pediatric radiography. This designation allows permit holders to perform pediatric radiography within the permit classifications listed on their permit only. All other projections on pediatric patients by limited radiologic technologists are prohibited.

42.9(2) An individual applying for an initial permit shall:

a. Be at least 18 years of age.

b. Submit the appropriate completed application.

c. Submit a nonrefundable \$60 application fee.

d. Submit proof of completion of formal education in all limited diagnostic radiography categories for which the individual is applying. In order to apply for the shoulder category, the individual must also apply for the chest or extremity category. In order to apply for the pediatric category, the individual must also apply for the chest or extremity category.

e. Submit proof of completion of testing as applicable for each permit category for which the individual is applying on the limited radiologic technologist permit. No examination is required for the categories of shoulder or pediatric.

(1) The following are passing scores:

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1. A score of at least 70 percent on the ARRT limited scope of practice in radiography examination core section and at least 70 percent on each category; or

2. A score of at least 70 percent on the American Chiropractic Registry of Radiologic Technologists Limited Radiography examination; or

3. A score of at least 70 percent on a department-approved examination.

(2) Three failed attempts on the examination in 42.9(2) "e"(1) "1" or "3" will require the individual to repeat the formal education or complete a department-approved review program.

(3) Each individual making application to take an examination as a limited radiologic technologist in 42.9(2) "e"(1) "1" or "3" must submit an application and nonrefundable fee of \$110 to the department each time the individual takes the examination.

f. Submit proof of completion of formal education and examination in the category to be added and a nonrefundable \$25 amendment fee to add chest, extremity or spine category to an existing limited radiologic technologist permit. A score of at least 70 percent on each category is required.

g. Submit proof of completion of formal education and a nonrefundable \$25 amendment fee to add shoulder or pediatric category to an existing limited radiologic technologist permit. No examination is required.

42.9(3) An individual renewing a current permit shall:

a. Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.

b. Report 12.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

42.9(4) An individual reinstating an expired permit shall submit the following:

a. Application to reinstate and nonrefundable \$60 application fee. If the permit is expired six months or more, all previous exemptions from this chapter are no longer valid and the individual is subject to all requirements of rule 641—42.9(136C).

b. Any continuing education hours due at time of renewal. If the permit is expired more than one year past the expiration date, 12.0 hours of continuing education obtained within the previous 24 months must be submitted.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

641—42.10(136C) Permit to practice as an X-ray equipment operator in either podiatric radiography or bone densitometry. After January 1, 2015, all individuals performing only bone densitometry must hold a bone densitometry permit.

42.10(1) An individual applying for an initial permit shall:

a. Be at least 18 years of age.

b. Submit the completed application.

c. Submit a nonrefundable \$25 application fee.

d. Submit proof of completion of a formal education that meets the department minimum training standards.

e. Submit proof of at least a 70 percent score on a department-approved examination.

(1) All podiatric X-ray equipment operators must pass the examination with a 70 percent score. After January 1, 2015, all bone densitometry equipment operators must submit proof of at least a 70 percent score on a department-approved examination.

(2) Three failed attempts on the examination in 42.10(1) "e"(1) will require the individual to repeat the formal education or complete a department-approved review program.

42.10(2) An individual renewing a current permit shall:

a. Renew annually by submitting a renewal application and a nonrefundable \$25 renewal fee.

b. Report 4.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

42.10(3) An individual reinstating an expired permit shall submit the following:

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a. Application to reinstate and nonrefundable \$25 application fee. If the permit is expired six months or more, all previous exemptions from this chapter are no longer valid and the individual is subject to all requirements of subrule 42.10(1).

b. Any continuing education hours due at time of renewal. If the permit is expired more than one year past the expiration date, 4.0 hours of continuing education obtained within the previous 24 months must be submitted.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

641—42.11 Reserved.

641—42.12(136C) Closed classification or category permits.

42.12(1) The following classifications or categories are closed to new applicants. Permits in the following classifications or categories that are expired for more than six months are not eligible to be reinstated, and individuals shall maintain current permits as outlined below:

a. Limited in-hospital radiologic technologist shall:

(1) Perform diagnostic radiography procedures, excluding CT and fluoroscopy, in a hospital setting only for specific body parts for which the individual is qualified.

(2) Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.

(3) Report 24.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

b. Limited nuclear medicine technologist shall:

(1) Perform nuclear medicine procedures for which the individual is qualified and has been authorized by the department.

(2) Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.

(3) Report 12.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

c. Limited radiologic technologist paranasal sinus shall:

(1) Perform diagnostic radiography procedures, excluding CT and fluoroscopy, specific to paranasal sinus.

(2) Renew annually by submitting a renewal application and a nonrefundable \$50 renewal fee.

(3) Report 6.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

42.12(2) An individual renewing a permit expired less than six months shall submit the following:

a. Application to reinstate and nonrefundable \$60 application fee.

b. Any continuing education hours due at time of renewal.

c. Proof that all stipulations of any order(s) of disciplinary or enforcement action have been satisfied.

641—42.13(136C) Combining permits for an individual qualifying for permits in more than one classification.

42.13(1) An individual applying for an initial permit in more than one classification at the same time shall combine classifications on one permit by:

a. Indicating each classification on the appropriate completed application;

b. Submitting the required documentation for each classification as outlined in each classification section; and

c. Submitting a nonrefundable \$100 application fee.

42.13(2) Permit holders shall add a classification to an existing permit by:

a. Completing the appropriate application;

b. Submitting the required documentation as outlined in the section specific to the classification to be added; and

c. Submitting a nonrefundable \$25 fee.

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42.13(3) An individual renewing a combined classification permit must submit the appropriately completed renewal application and submit a nonrefundable \$75 renewal fee.

42.13(4) An individual shall submit a total of 24.0 hours of continuing education obtained within the biennium indicated on the individual's permit. If the permit includes the radiologist assistant classification, then the individual must submit a total of 50.0 hours of continuing education obtained within the biennium indicated on the individual's permit.

641—42.14 to 42.17 Reserved.

PERMIT HOLDER SUBMISSION OF CONTINUING EDUCATION

641—42.18(136C) Submission of proof of completion of continuing education by permit holder to meet continuing education requirements to renew or reinstate a permit.

42.18(1) A permit holder who has a current ARRT or NMTCB registration that has been renewed within 60 days prior to the submission of the permit renewal application required by these rules shall be credited the number of hours recognized by the ARRT or NMTCB registration, or

42.18(2) A permit holder must submit proof of completion of continuing education activities recognized by ARRT or NMTCB.

a. Acceptable proof of completion must be documentation signed and dated by the continuing education provider that includes the participant's name, title of the activity, approval number for the activity, dates of attendance, number of contact hours for the activity, name of the approving organization, and signature of the sponsor or instructor or authorized representative of the sponsor or instructor.

b. Continuing education activities that are lecture presentations may not be repeated for credit in the same biennium.

c. All continuing education activities that are not lecture presentations may not be repeated for credit in the same or any subsequent biennium.

42.18(3) Podiatric X-ray equipment operator permit holders may submit activities as described in 42.18(2) or may submit activities sponsored by the American Podiatric Medical Association or the Iowa Podiatric Medical Society.

a. Acceptable proof of completion must be documentation signed and dated by the continuing education provider that includes the participant's name, title of the activity, approval number for the activity, dates of attendance, number of contact hours for the activity, the name of the approving organization, and signature of the sponsor or instructor or authorized representative of the sponsor or instructor.

b. Continuing education activities that are lecture presentations may not be repeated for credit in the same biennium.

c. All continuing education activities that are not lecture presentations may not be repeated for credit in the same or any subsequent biennium.

641—42.19 and 42.20 Reserved.

ADMINISTRATIVE ITEMS AND GROUNDS FOR DISCIPLINARY ACTION

641—42.21(136C) Administrative items.

42.21(1) A nonrefundable \$25 fee shall be assessed for each check returned for any reason. All fees for returned checks plus original fees must be paid by certified bank check or money order.

42.21(2) A permit is valid from the date of issuance until the expiration date, unless otherwise revoked or suspended.

42.21(3) The department may at any time require further documentation to ensure compliance with these rules.

42.21(4) The permit holder shall make the permit available at the individual's place of employment. If the permit holder works at more than one facility, a duplicate of the permit shall be kept at each facility.

42.21(5) The permit holder must maintain proof of continuing education for at least three years.

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42.21(6) Continuing education obtained to satisfy disciplinary or enforcement action or as part of a corrective action plan may not be reported to meet continuing education requirements.

42.21(7) All permit holders are subject to a department audit at any time.

641—42.22(136C) Rules of conduct, self-reporting requirements, and enforcement actions for all permit holders.

42.22(1) Rules of conduct. These are mandatory standards of minimally acceptable professional conduct intended to promote the protection, safety, and comfort of patients. Any individual who fails to meet or allows any other individual to fail to meet the following standards may be subject to enforcement actions as outlined in subrule 42.22(3). The following shall be grounds for disciplinary action:

a. Failing to perform with reasonable skill and safety all procedures accepted under this chapter's educational guidelines and allowed under the individual's permit.

b. Operating as a permitted individual without meeting the applicable requirements of this chapter. This includes performing procedures not allowed under the individual's current permit.

c. Failing to report immediately to the department any individual who may be operating as a permit holder and who does not meet the requirements of this chapter.

d. Engaging in any practice that results in unnecessary danger to a patient's life, health, or safety. This includes delegating or accepting the delegation of any function when the delegation or acceptance could cause unnecessary danger.

e. Engaging in any action that the department determines may jeopardize the health and safety of the public, other staff or the permit holder. These actions shall include but not be limited to:

(1) A misdemeanor or felony which may impair or limit the individual's ability to perform the duties authorized by the individual's permit.

(2) Any disciplinary action brought against the individual in connection with a certificate or license issued from a certifying or licensing entity.

(3) Being found guilty of incompetence or negligence during the individual's performance as a permit holder.

f. Failing to conform to applicable state and federal statutes and rules. This includes any action that might place a facility in noncompliance with Iowa statutes and rules.

g. Practicing when there is an actual or potential inability to perform with reasonable skill and safety due to illness, use of alcohol, drugs, chemicals, or any other material, or as the result of any mental or physical condition.

h. Engaging in any unethical conduct or conduct likely to deceive, defraud, or harm the public; or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient.

i. Revealing privileged communication from or relating to former or current patients except as permitted by law.

j. Improperly managing patient records, including failing to maintain adequate records, failing to furnish records, or making, causing, or allowing anyone to make a false, deceptive, or misleading entry into a patient record.

k. Providing false or misleading information that is directly related to the care of a former or current patient.

l. Interpreting or rendering a diagnosis for a physician based on a diagnostic image or prescribing medications or therapies.

m. Failing to immediately report to a supervisor information concerning an error made in connection with imaging, treating, or caring for a patient. This includes any departure from the normal standard of care and behavior that is negligent.

n. Employing fraud or deceit to obtain, attempt to obtain or renew a permit under this chapter or in connection with a certification or license issued from a certifying or licensing entity. This includes altering documents, failing to provide complete and accurate responses or information, or indicating falsely in writing that a permit is valid when that is not the case.

o. Failure to provide truthful, accurate, unaltered, or nondeceptive information related to continuing education activities to the department or a record keeper.

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p. Assisting others to provide false, inaccurate, altered, or deceptive information related to continuing education to this department or a record keeper. This includes sharing answers, providing or using false certificates of participation, or verifying continuing education hours that have not been earned.

q. Failure to pay all fees or costs required to meet the requirements of this chapter. Penalties for working without a current permit will be considered on a case-by-case basis.

r. Failure to respond to an audit request or failure to provide proper documentation.

s. Submitting false information to a facility that might place the facility in noncompliance with any federal or state statutes or laws.

t. Engaging in any conduct that subverts or attempts to subvert a department investigation.

u. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation by the department.

v. Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.

w. Sexual harassment of a patient, student or supervisee. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal and physical conduct of a sexual nature.

x. Violating a statute of this state, another state, or the United States, without regard to its designation as either a felony or misdemeanor, including but not limited to a crime involving dishonesty, fraud, theft, embezzlement, controlled substances, substance abuse, assault, sexual abuse, sexual misconduct, or homicide. A copy of the record of conviction or plea of guilty is conclusive evidence of the violation.

y. Having a permit, license or certification related to the classification of the permit issued to the individual 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.

z. Failure to respond within 30 days of receipt of communication from the department.

42.22(2) Self-reporting. Each permit holder shall:

a. Submit a report to the department within five days of the final disposition of all criminal proceedings, convictions, or military court-martials involving alcohol or illegal drug use while operating as a permit holder, sex-related infractions, or patient-related infractions in any state, territory, or country.

b. Submit a written report to the department within five days of the initial charge and within five days of the final disposition of any disciplinary action brought against the individual in connection with a certificate or license issued from a certifying or licensing entity, or any disciplinary action brought against the individual by an employer or patient.

42.22(3) Enforcement actions. Enforcement actions may include, but are not limited to, denial, probation, suspension or revocation of a permit, directed corrective action, and civil penalty.

641—42.23(136C) Procedures for demand for information, notice of proposed action, and orders for penalties, suspensions, revocations, and civil penalties for all individuals under this chapter. These actions may be imposed on any permit holder who violates any rule in this chapter.

42.23(1) Demand for information.

a. The department may issue a demand for information for the purpose of determining whether any further action shall be taken. The demand shall state the alleged violations and allow the individual 20 days from the date of the letter to file a written answer with the department.

b. The individual must file a written answer to the department. The answer shall specifically admit or deny each allegation or charge made in the demand for information and provide fact and law on which the answer relies, set forth reasons why the demand should not have been issued, and if the requested information is not provided, the reasons why it is not provided.

c. Upon review of the answer, the department may institute the next level of proceeding or consider the matter closed. If no answer is filed, the department shall institute the notice of proposed action.

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42.23(2) Procedures for enforcement actions.*a. Notice of proposed action.*

(1) In response to an alleged violation of any provision of the Iowa Code, these rules, or any order issued by the department, the department may issue a written notice of proposed action. The notice of proposed action shall concisely state the alleged violation(s), the action the department is proposing, the time period in which a written response must be received, and the process for requesting a hearing.

(2) A written response must state any facts, explanations, or arguments denying the violations or must demonstrate any extenuating circumstances, error in the notice, or other reason why the proposed action should not be imposed. Responses may also request remission or mitigation of any penalty.

(3) If a request for a hearing is received within the allotted time period, the proposed action shall be suspended pending the outcome of the hearing. Prior to or at the hearing, the department may rescind the notice of proposed action upon satisfaction that the reason for the proposed action has been resolved.

(4) If no answer is filed, the department shall institute the order.

b. Order. An order may be issued upon response to the notice of proposed action or if no answer to the notice has been filed. The order may institute a proceeding to impose a penalty or suspend, revoke, or place on probation the individual's permit, or issue a civil penalty. An order shall concisely state the violation(s), the action the department has imposed, the effective date of the order, the time period for written response to be received by the department, and the process for requesting a hearing. If there has been consent in writing to the notice of proposed action, no written response to the order is necessary.

(1) If a request for a hearing is received within the allotted time period, the proposed action of the order shall be suspended pending the outcome of the hearing. Prior to or at the hearing, the department may rescind the order upon satisfaction that the reason for the proposed action has been resolved.

(2) If no answer is filed, the department shall institute the order. A consent to the order shall constitute a waiver to a hearing, findings of fact and conclusions of law, and of all right to seek department and judicial review or to contest the validity of the order in any form as to those matters which have been consented to or agreed to or on which a hearing has not been requested. An order that has been consented to shall have the same force and effect as an order made after hearing by a presiding officer or the department and shall be effective as provided in the order. Failure to comply with an order either consented to or validated by a hearing officer shall result in further enforcement action.

c. Civil penalty. Before instituting any proceeding to impose a civil penalty, the department shall serve written notice of violation upon the individual charged. This notice shall be included in the notice of proposed action or order issued. The notice of proposed action or order shall specify the amount of each proposed penalty for each alleged violation. The notice or order shall state that the amount charged may be paid as specified or protested in its entirety or in part. Upon final action of a civil penalty, payment must be made within the specified time stated in the order or the department may refer the matter to the attorney general for collection.

d. Settlement and compromise. At any time after the issuance of a notice or order designating the time and place of hearing in response to an order, the department and the regulated individual may enter into a stipulation for a settlement or compromise of the notice or order. The stipulation of compromise shall be subject to approval by the designated presiding officer or, if none has been designated, by the chief administrative law judge. The presiding officer or chief administrative law judge may order such adjudication of the issued notice or order as deemed to be required in the public interest to dispose of the proceeding. If approved, the terms of the settlement or compromise shall be embodied in a decision or order settling and discontinuing the proceeding.

641—42.24 and 42.25 Reserved.

DEPARTMENT APPROVAL OF CONTINUING EDUCATION ACTIVITIES

641—42.26(136C) Department approval of continuing education activities.

42.26(1) All continuing education activities must meet the definition of continuing education activities as defined in 641—42.2(136C).

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42.26(2) On March 13, 2013, the department will no longer review or approve continuing education activities.

42.26(3) All continuing education activities with department approval are valid until the expiration date issued for that activity and will not be renewed.

641—42.27 to 42.29 Reserved.

FORMAL EDUCATION

641—42.30(136C) Requirements for formal education. Formal education must meet the following minimum requirements:

42.30(1) General radiologic technology formal education must be recognized by the ARRT to allow students to qualify for the general radiography examination.

42.30(2) Nuclear medicine technology formal education must be recognized by the ARRT or NMTCB to allow students to qualify for the nuclear medicine technology examination.

42.30(3) Radiation therapy formal education must be recognized by the ARRT to allow students to qualify for the radiation therapy examination.

42.30(4) Radiologist assistant formal education must provide training to allow students to qualify for a department-approved radiologist assistant examination.

42.30(5) Limited radiologic technologist formal education must meet the minimum standards specified in 641—42.31(136C).

42.30(6) X-ray equipment operator formal education must meet the minimum standards as outlined in 641—42.32(136C) or 641—42.33(136C).

641—42.31(136C) Standards for formal education for limited radiologic technologists.

42.31(1) The formal education may be a single offering that meets all standards of all categories, or it may be offered individually specific to the category the provider wishes to offer.

42.31(2) The following are the minimum standards:

a. A principal instructor shall:

(1) Be an Iowa-licensed chiropractor teaching spine and extremities categories only; or

(2) Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or

(3) Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

b. A clinical instructor shall:

(1) Be an Iowa-licensed chiropractor teaching spine and extremities categories only; or

(2) Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or

(3) Be an Iowa-permitted limited radiologic technologist in the category of instruction and have at least two years of current experience in radiography; or

(4) Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

c. Clinical instructors shall be supervised by the principal instructor.

d. A principal instructor may also act as clinical instructor, if applicable.

e. Classroom and clinical standards are listed below:

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Category	Classroom Hours	Clinical Practice Projections	Clinical Competency Projections
Core: completed by all trainees	60		
Chest	20	30 PA or LAT	5 PA, 5 LAT
Upper extremity	20	30 (any projections)	10 (only 2 of any projection allowed)
Lower extremity	20	30 (any projections)	10 (only 2 of any projection allowed)
Shoulder	20	20 (any projections)	6 (only 2 of any projection allowed)
Spine	20	30 (any projections)	10 (only 2 of any projection allowed)
Pediatric: add on to chest	8 of initial pediatrics	20 (any projections)	2 PA, 2 LAT
Pediatric: add on to upper extremity	8 of initial pediatrics	20 (any projections)	10 (only 2 of any projection allowed)
Pediatric: add on to lower extremity	8 of initial pediatrics	20 (any projections)	10 (only 2 of any projection allowed)

(1) All competency testing for limited radiography shall be directly supervised by the principal or clinical instructor.

(2) Clinical instructors shall directly supervise all students before the student's competency for a specific projection is documented and indirectly supervise after the student's competency for a specific projection is documented.

(3) Current permit holders completing formal education to add a category do not need to repeat the core curriculum.

42.31(3) Department approval is required before implementing any formal education or making any changes to a formal education offering.

42.31(4) Administrative items for all formal education:

a. The department reserves the right to audit or evaluate any aspect of the formal education or student progress.

b. The department may at any time require further documentation.

641—42.32(136C) Standards for formal education for X-ray equipment operators in podiatric radiography.

42.32(1) The following are the minimum standards:

a. A principal instructor shall:

(1) Be an Iowa-licensed podiatrist; or

(2) Be an Iowa-permitted general radiologic technologist and have at least two years of current experience in radiography; or

(3) Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

b. A clinical instructor shall:

(1) Be an Iowa-licensed podiatrist; or

(2) Be an Iowa-permitted limited radiologic technologist in the category of extremities and have at least two years of current experience in radiography; or

(3) Be an Iowa-permitted X-ray equipment operator in podiatry and have at least two years of current experience in radiography; or

(4) Be an Iowa-permitted general radiologic technologist and have at last two years of current experience in radiography; or

(5) Hold a current ARRT registration and have at least two years of current experience in radiography if the clinical site is located outside of Iowa.

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- c.* Clinical instructors shall be supervised by the principal instructor.
 - d.* A principal instructor may also act as clinical instructor, if applicable.
 - e.* The following are classroom and clinical standards:
 - (1) A minimum of 8.0 hours of classroom instruction to include radiation safety, equipment operation, patient care, and anatomy.
 - (2) Clinical instruction to include positioning and a minimum of 20 projections excluding the competency projections.
 - (3) Clinical competency projections shall include 10 projections with only 2 of any single projection allowed to count toward the competency projections.
 - (4) All competency testing shall be directly supervised by the principal or clinical instructor.
 - (5) Clinical instructors shall directly supervise all students before the student's competency for the specific projection is documented and indirectly supervise after the student's competency for the specific projection is documented.
- 42.32(2)** Department approval is required before implementing any formal education or making any changes to a formal education offering.
- 42.32(3)** Administrative items for all formal education:
- a.* The department reserves the right to audit or evaluate any aspect of the formal education or student progress.
 - b.* The department may at any time require further documentation.

641—42.33(136C) Standards for formal education for X-ray equipment operators in bone densitometry.

- 42.33(1)** The following are the minimum standards:
- a.* A principal instructor shall have at least two years of current experience in radiography and bone densitometry and shall:
 - (1) Be an Iowa-permitted general radiologic technologist; or
 - (2) Hold a current ARRT registration if the clinical site is located outside of Iowa.
 - b.* A clinical instructor shall have at least two years of current experience in radiography and bone densitometry and shall:
 - (1) Be an Iowa-permitted limited radiologic technologist; or
 - (2) Be an Iowa-permitted X-ray equipment operator in bone densitometry; or
 - (3) Be an Iowa-permitted general radiologic technologist; or
 - (4) Hold a current ARRT registration if the clinical site is located outside of Iowa.
 - c.* Clinical instructors shall be supervised by the principal instructor.
 - d.* A principal instructor shall also act as clinical instructor, if applicable.
 - e.* The following are classroom and clinical standards:
 - (1) A minimum of 8.0 hours of classroom instruction to include radiation safety, equipment operation, quality control, patient care, and anatomy.
 - (2) Clinical instruction to include positioning and a minimum of 10 projections excluding the competency projections.
 - (3) Clinical competency projections shall include 5 projections.
 - (4) All competency testing shall be directly supervised by the principal or clinical instructor.
 - (5) Clinical instructors shall directly supervise all students before the student's competency for the specific projection is documented and indirectly supervise after the student's competency for the specific projection is documented.
- 42.33(2)** Department approval is required before implementing any formal education or making any changes to a formal education offering.
- 42.33(3)** Administrative items for all formal education:
- a.* The department reserves the right to audit or evaluate any aspect of the formal education or student progress.

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b. The department may at any time require further documentation.

These rules are intended to implement Iowa Code sections 136C.3, 136C.4, 136C.5, 136C.10, and 136C.14.

[Filed 1/9/13, effective 3/13/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0578C

PUBLIC HEALTH DEPARTMENT[641]

Adopted and Filed

Pursuant to the authority of Iowa Code section 135.143, the Department of Public Health hereby amends Chapter 113, "Public Health Response Teams," Iowa Administrative Code.

The rules in Chapter 113 describe how the Division of Acute Disease Prevention and Emergency Response, Center for Disaster Operations and Response, establishes, registers, and approves public health response teams to supplement and support disrupted or overburdened local medical and public health personnel, hospitals, and resources in the event of a disaster or threatened disaster or other incident as defined in Iowa Code section 135.143. The current language defines priorities and provides guidance related to specific teams. The number and scope of the teams have been distinctly defined since Chapter 113 was originally adopted. The term "public health response team" currently includes disaster medical assistance teams, an environmental health response team, a logistical support response team, and an Iowa mortuary operational response team. The epidemiological response team is no longer supported. These amendments broaden the priorities and guidance to include all the teams, rather than have language limited to specific guidance for individual teams.

Notice of Intended Action was published in the November 28, 2012, Iowa Administrative Bulletin as **ARC 0474C**. One question/comment was received regarding the participation of a licensed dentist on a PHRT. Additional information was shared with the commenter; no change was made to the rule amendments. The adopted amendments are identical to those published under Notice.

The State Board of Health adopted these amendments on January 13, 2013.

After analysis and review of this rule making, no impact on jobs has been found. These amendments do not change the scope of work or duties of the response teams.

These amendments are intended to implement Iowa Code section 135.143.

These amendments will become effective on March 13, 2013.

The following amendments are adopted.

ITEM 1. Rescind the definitions of "Epidemiology response team," "Physician," "Registered nurse" and "Sponsor agency" in rule **641—113.1(135)**.

ITEM 2. Adopt the following **new** definitions of "Iowa mortuary operational response team" and "Logistical support response team" in rule **641—113.1(135)**:

"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.

ITEM 3. Amend rule **641—113.1(135)**, definitions of "Public health response team" and "Public health response team member," as follows:

"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 by the department, a hospital or other entity and

PUBLIC HEALTH DEPARTMENT[641](cont'd)

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" shall include disaster medical assistance teams, an environmental health response teams team, epidemiology response teams, 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," "~~DMAT member,~~" "~~EHRT member,~~" or "~~EpiRT 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.

ITEM 4. Amend subrule 113.2(1), introductory paragraph, as follows:

113.2(1) The department, through the division of acute disease prevention and emergency response, center for disaster operations and response, shall establish, register, and approve public health response teams, ~~including at a minimum five DMATs and one EHRT,~~ to supplement and support disrupted or overburdened local medical and public health personnel, hospitals, and resources in the event of a disaster or threatened disaster or other incident as defined in Iowa Code section 135.143. The primary purpose of the 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 may also be requested to respond to an out-of-state disaster or emergency pursuant to the Emergency Management Assistance Compact at Iowa Code section 29C.21.

ITEM 5. Amend subrule 113.2(2) as follows:

113.2(2) ~~DMAT and EHRT~~ PHRTs shall be established, registered and approved pursuant to this chapter. ~~Other~~ Additional PHRTs may be established, registered and approved as necessary upon written order of the director.

ITEM 6. Amend rule 641—113.5(135) as follows:

641—113.5(135) ~~Disaster medical assistance~~ Public health response team.

113.5(1) *General requirements.*

a. An entity may make application to the department to be a sponsor agency of a ~~DMAT~~ PHRT pursuant to subrule 113.3(1). An individual may make application to the department to be a member of a ~~DMAT~~ PHRT pursuant to subrule 113.4(1).

b. The department, in conjunction with the sponsor agencies, shall establish the ~~DMAT operational procedures~~ Iowa Volunteer Public Health Response Team Operational Procedures Manual. The operational procedures shall be in writing and shall be provided to each ~~DMAT~~ PHRT member. All ~~DMAT~~ PHRT members and sponsor agencies shall follow the ~~DMAT~~ PHRT operational procedures as established by the department. The Iowa ~~DMAT~~ Volunteer Public Health Response Team Operational Procedures Manual is available through the Iowa Department of Public Health, Center for Disaster Operations and Response, Lucas State Office Building, Des Moines, Iowa 50319-0075.

c. If the department notifies a ~~DMAT,~~ DMAT PHRT member, or sponsor agency of a violation of Iowa Code section 135.143, this chapter, or an operational procedure, the ~~DMAT,~~ DMAT PHRT member, or sponsor agency shall correct the deficiency or violation identified by the department within a time frame determined by the department. If a ~~DMAT,~~ DMAT PHRT member, or sponsor agency 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 113.3(2) or 113.4(2).

113.5(2) *Team composition.*

a. A ~~DMAT~~ PHRT shall be comprised of ~~a minimum of 35~~ health care professionals and administrative personnel as identified in the Iowa ~~DMAT~~ Volunteer Public Health Response Team Operational Procedures Manual.

b. The sponsor agency for each team shall be responsible for maintaining adequate staffing.

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113.5(3) Licensure and educational requirements.

a. Each ~~DMAT~~ PHRT member shall hold and maintain an active unrestricted license, registration, or certification to practice in Iowa in the member's respective medical or health care profession.

b. Each ~~DMAT~~ PHRT member shall complete ~~the following courses or shall complete other substantially similar courses approved by the department:~~ required training as listed in the Iowa Volunteer Public Health Response Team Operational Procedures Manual, including training specified in respective team annexes.

- ~~(1) Incident command structure;~~
- ~~(2) Weapons of mass destruction awareness; and~~
- ~~(3) Hazardous materials awareness or operations.~~

c. In addition to the requirements in paragraph 113.5(3) "b," the ~~DMAT's~~ PHRT leadership shall complete training ~~in~~ as specified in the team annex to the Iowa Volunteer Public Health Response Team Operational Procedures Manual.

- ~~(1) Hospital emergency incident command structure; and~~
- ~~(2) Risk communication.~~

d. A sponsor agency shall provide specific position training to ~~DMAT~~ PHRT members as determined to be necessary by the sponsor agency and as approved by the department.

e. A sponsor agency, in conjunction with the department, shall develop and implement training exercises to test the team's notification process, deployment readiness, and response capabilities.

f. The sponsor agency shall be responsible for documenting each ~~DMAT~~ PHRT member's completion of required training.

113.5(4) Deployment and standdown.

a. ~~DMATs~~ PHRTs shall prepare to deploy within two to four hours of notification by the department. ~~DMATs~~ PHRTs shall not self-deploy and shall not be covered by the provisions of Iowa Code section 135.143 and this chapter if ~~self-deployed~~ the PHRTs self-deploy or are deployed by another agency or entity.

b. On-call team schedules shall be established and distributed by the department and shall be followed by the ~~DMATs~~ PHRTs and sponsor agencies.

c. Deployment and standdown procedures are outlined in the Iowa ~~DMAT~~ Volunteer Public Health Response Team Operational Procedures Manual and shall be followed by all ~~DMAT~~ PHRT members.

ITEM 7. Rescind rule ~~641—113.6(135)~~.

ITEM 8. Renumber rules ~~641—113.7(135)~~ and ~~641—113.8(135)~~ as ~~641—113.6(135)~~ and ~~641—113.7(135)~~.

[Filed 1/9/13, effective 3/13/13]

[Published 2/6/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 2/6/13.

ARC 0592C

TRANSPORTATION DEPARTMENT[761]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 307.10 and 307.12, the Iowa Department of Transportation, on January 15, 2013, adopted an amendment to Chapter 615, "Sanctions," Iowa Administrative Code.

Notice of Intended Action for this amendment was published in the November 14, 2012, Iowa Administrative Bulletin as **ARC 0438C**.

Iowa Code section 321.210A was amended in 2009 Iowa Acts, chapter 130, section 11, which eliminated the authority of the Department to determine whether a person has the ability to pay a criminal penalty, fine, surcharge or court costs before the Department suspends the person's driver's

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license for failure to pay. The amendment brings the rules up to date to comply with Iowa Code section 321.210A.

These rules do not provide for waivers. Any person who believes that the person's circumstances meet the statutory criteria for a waiver may petition the Department for a waiver under 761—Chapter 11.

This amendment is identical to the one published under Notice of Intended Action.

After analysis and review of this rule making, no impact on jobs has been found.

This amendment is intended to implement Iowa Code section 321.210A.

This amendment will become effective March 13, 2013.

Rule-making action:

Amend rule 761—615.22(321) as follows:

761—615.22(321) Suspension for nonpayment of fine, penalty, surcharge or court costs.

615.22(1) *Report to the department.* The department shall suspend a person's privilege to operate motor vehicles in Iowa:

a. When when the department is notified by a clerk of the district court on Form No. 431037 that the person has been convicted of violating a law regulating the operation of motor vehicles, that the person has failed to pay the fine, penalty, surcharge or court costs arising out of the conviction, and that 60 days have elapsed since the person was mailed a notice of nonpayment from the clerk of the district court, ~~and.~~

~~*b. When, in accordance with subrule 615.22(2), the person has not timely raised the defense of inability to pay, or the department determines that the person is able to pay the fine, penalty, surcharge and court costs.*~~

615.22(2) *Ability to pay.*

a. The department shall presume that a person is able to pay the fine, penalty, surcharge and court costs when it receives the "Notice to Suspend" copy of Form No. 431037 from the clerk of the district court.

b. The department shall not consider inability to pay as a defense to license suspension unless the person files Form No. 431038 with the department within 45 days after the clerk of the district court mailed notice of nonpayment to the person.

c. If the department determines that the person is unable to pay, the department shall notify the person and the clerk of the district court of that decision and shall take no further action. If the department determines that the person is able to pay, the department shall suspend the person's privilege to operate motor vehicles in Iowa as outlined in subrule 615.22(1).

615.22(3) *Suspension.*

a. The suspension period shall begin 30 days after the notice of suspension is served.

b. The suspension shall continue until the department has issued a notice terminating the suspension. The department shall terminate the suspension when it receives evidence that all appropriate payments have been made.

c. An informal settlement, hearing or appeal to contest the suspension shall be limited to a determination of whether the facts required by Iowa Code section 321.210A and this ~~rule~~ subrule are true. The merits of the conviction shall not be considered.

615.22(2) Reserved.

This rule is intended to implement Iowa Code section 321.210A.

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