



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.

STEPHANIE A. HOFF, Administrative Code Editor

Telephone: (515)281-3355

Fax: (515)281-5534

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 2015

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

<u>ISSUE NUMBER</u>	<u>SUBMISSION DEADLINE</u>	<u>ISSUE DATE</u>
12	Wednesday, November 18, 2015	December 9, 2015
13	Wednesday, December 2, 2015	December 23, 2015
14	Wednesday, December 16, 2015	January 6, 2016

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*****

EDUCATIONAL EXAMINERS BOARD[282]

Professional school counselor endorsement—practicum and internship hours, 13.28, 27.3 IAB 11/11/15 ARC 2237C	Room 3 Southwest Grimes State Office Bldg. Des Moines, Iowa	December 2, 2015 1 p.m.
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ENGINEERING AND LAND SURVEYING EXAMINING BOARD[193C]

Fundamentals of land surveying examination application process; board verification of education and experience of candidates for engineering licensure, 3.2(2), 4.1(2) IAB 10/28/15 ARC 2219C	Bureau Office, Suite 350 200 E. Grand Ave. Des Moines, Iowa	November 17, 2015 9 a.m.
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ENVIRONMENTAL PROTECTION COMMISSION[567]

Application fees for construction and operation of air pollution emitting equipment; fees for asbestos notifications, amend chs 20, 22, 23, 31, 33; adopt ch 30 IAB 10/28/15 ARC 2222C	Public Library 400 Willow Ave. Council Bluffs, Iowa	November 18, 2015 6 p.m.
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Air Quality Bureau, Suite 1 7900 Hickman Rd. Windsor Heights, Iowa	November 19, 2015 10 a.m.
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Public Library 2950 Learning Campus Dr. Bettendorf, Iowa	November 24, 2015 6 p.m.
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HOMELAND SECURITY AND EMERGENCY MANAGEMENT DEPARTMENT[605]

Fair information practices, amendments to ch 5 IAB 10/28/15 ARC 2216C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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Contested cases, amendments to ch 6 IAB 10/28/15 ARC 2215C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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Local emergency management, amendments to ch 7 IAB 10/28/15 ARC 2214C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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Criteria for awards or grants, amendments to ch 8 IAB 10/28/15 ARC 2213C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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Iowa comprehensive plan, amendments to ch 9 IAB 10/28/15 ARC 2212C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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Repair, calibration, and maintenance of radiological monitoring, detection, and survey equipment, amendments to ch 11 IAB 10/28/15 ARC 2211C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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Homeland security and emergency response teams, amendments to ch 12 IAB 10/28/15 ARC 2210C	Cyclones Conference Room, Suite 500 7900 Hickman Rd. Windsor Heights, Iowa	November 17, 2015 11 a.m.
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HUMAN SERVICES DEPARTMENT[441]

Implementation of Medicaid modernization initiative, amend chs 36, 74, 75, 77 to 79, 81 to 83, 85, 90; rescind ch 92 IAB 11/11/15 ARC 2242C	<i>Cedar Rapids Service Area</i> Whipple Auditorium, Public Library 450 5th Ave. SE Cedar Rapids, Iowa	December 2, 2015 9 to 11 a.m.
	<i>Eastern Service Area</i> Boardroom, Administration Bldg. 600 W. 4th St. Davenport, Iowa	December 2, 2015 1 to 3 p.m.
	<i>Des Moines Service Area</i> Conference Room 1-1A Polk County River Place 2309 Euclid Ave. Des Moines, Iowa	December 4, 2015 9 to 11 a.m.
	<i>Northern Service Area</i> Conf. Rm. 201, Pinecrest Office Bldg. Black Hawk County DHS 1407 Independence Ave. Waterloo, Iowa	December 4, 2015 1 to 3 p.m.
	<i>Western Service Area</i> Public Library 200 Pearl St. Council Bluffs, Iowa	December 4, 2015 2 to 4 p.m.
Managed care, adopt ch 73; amend ch 88 IAB 11/11/15 ARC 2241C	<i>Cedar Rapids Service Area</i> Whipple Auditorium, Public Library 450 5th Ave. SE Cedar Rapids, Iowa	December 2, 2015 9 to 11 a.m.
	<i>Eastern Service Area</i> Boardroom, Administration Bldg. 600 W. 4th St. Davenport, Iowa	December 2, 2015 1 to 3 p.m.
	<i>Des Moines Service Area</i> Conference Room 1-1A Polk County River Place 2309 Euclid Ave. Des Moines, Iowa	December 4, 2015 9 to 11 a.m.
	<i>Northern Service Area</i> Conf. Rm. 201, Pinecrest Office Bldg. Black Hawk County DHS 1407 Independence Ave. Waterloo, Iowa	December 4, 2015 1 to 3 p.m.
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INSURANCE DIVISION[191]		
Prior authorization—prescription drug benefits, ch 79 IAB 10/28/15 ARC 2228C	Division Offices, Fourth Floor Two Ruan Center 601 Locust St. Des Moines, Iowa	November 18, 2015 10 a.m.

PROFESSIONAL LICENSURE DIVISION[645]

<p>Polysomnographic technologists and respiratory care and polysomnography practitioners—licensure, practice, discipline, continuing education, amendments to chs 261 to 263, 265 IAB 10/28/15 ARC 2224C</p>	<p>Fifth Floor Conference Room 526 Lucas State Office Bldg. Des Moines, Iowa</p>	<p>November 17, 2015 9 to 9:30 a.m.</p>
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REVENUE DEPARTMENT[701]

<p>Qualification for manufacturing exemption, 15.3(3), 18.29(7), 18.58, 219.11, 219.12, 219.13(3), 230.5, 230.14 to 230.22 IAB 11/11/15 ARC 2239C (See also ARC 2178C, IAB 9/30/15)</p>	<p>Auditorium Wallace State Office Bldg. Des Moines, Iowa</p>	<p>December 1, 2015 2 p.m.</p>
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STATE PUBLIC DEFENDER[493]

<p>Claims of contract attorneys and other professionals, 1.3(2), 11.3, 11.7(2), 11.9, 12.2, 12.5(5), 12.8(1), 13.2 IAB 11/11/15 ARC 2233C</p>	<p>Conference Room 424, Fourth Floor Lucas State Office Bldg. Des Moines, Iowa</p>	<p>December 4, 2015 10 a.m.</p>
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The following list will be updated as changes occur.

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

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

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

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ARC 2237C

EDUCATIONAL EXAMINERS BOARD[282]

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 272.2(1)“a,” the Board of Educational Examiners hereby gives Notice of Intended Action to amend Chapter 13, “Issuance of Teacher Licenses and Endorsements,” and Chapter 27, “Issuance of Professional Service Licenses,” Iowa Administrative Code.

The proposed amendments would change the number of practicum and internship hours required for a licensee to add the K-8 and 5-12 professional school counselor endorsement to both an Iowa teaching license and an Iowa professional service license. Currently, Iowa requires 500 hours at the K-8 level and 500 hours at the 5-12 level. This equates to approximately 12.5 weeks for each endorsement or 25 weeks for both. This significantly exceeds the required 100-hour practicum and 600-hour internship required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which sets the national standards for counseling. The proposed changes would bring Iowa’s standards into alignment with national standards and cease the imposition of an undue hardship on individuals seeking both endorsements.

Any interested person may make written comments or suggestions on the proposed amendments before 4 p.m. on Friday, December 4, 2015. Written comments and suggestions should be addressed to Kim Cunningham, Board Secretary, Board of Educational Examiners, Grimes State Office Building, East 14th Street and Grand Avenue, Des Moines, Iowa 50319-0147; or sent by e-mail to kim.cunningham@iowa.gov; or by fax to (515)281-7669.

Any interested party or persons may present their views either orally or in writing at the public hearing that will be held Wednesday, December 2, 2015, at 1 p.m. in Room 3SW, Grimes State Office Building, East 14th Street and Grand Avenue, Des Moines, Iowa.

At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the proposed amendments. Persons who wish to make oral presentations at the public hearing may contact the Executive Director, Board of Educational Examiners, at the above address, or at (515)281-5849, prior to the date of the public hearing.

Any person who intends to attend the public hearing and requires special accommodations for specific needs, such as a sign language interpreter, should contact the office of the Executive Director at (515)281-5849.

These amendments are subject to waiver pursuant to 282—Chapter 6.

After analysis and review of this rule making, there is no anticipated impact on jobs.

These amendments are intended to implement Iowa Code section 272.2(1)“a.”

The following amendments are proposed.

ITEM 1. Amend subparagraph **13.28(26)“c”(12)** as follows:

~~(12) Teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with elementary and middle school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group counseling, developmental classroom guidance, and consultation. The candidate will complete a preservice supervised practicum of a minimum of 100 hours, and at least 40 of these hours must be direct service. Candidates will complete a supervised internship for a minimum~~

EDUCATIONAL EXAMINERS BOARD[282](cont'd)

of 600 hours, and at least 240 of these hours must be direct service. For candidates seeking both the K-8 and 5-12 professional school counselor endorsements, a minimum of 100 hours of the practicum or internship experiences listed above must be completed at each of the desired endorsement levels.

ITEM 2. Amend subparagraph **13.28(27)“c”(2)** as follows:

(2) ~~The teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with middle and secondary school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group work, developmental classroom guidance, and consultation. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 13.28(26)“c”(12).~~

ITEM 3. Amend subparagraph **27.3(1)“c”(2)** as follows:

(2) ~~The teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with elementary and middle school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group counseling, developmental classroom guidance, and consultation. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 282—subparagraph 13.28(26)“c”(12).~~

ITEM 4. Amend subparagraph **27.3(2)“c”(2)** as follows:

(2) ~~The teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with middle and secondary school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group work, developmental classroom guidance, and consultation. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 282—subparagraph 13.28(26)“c”(12).~~

ARC 2240C**ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351]****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 68B.32A(1), the Iowa Ethics and Campaign Disclosure Board hereby gives Notice of Intended Action to amend Chapter 4, “Campaign Disclosure Procedures,” Iowa Administrative Code.

These proposed amendments are intended to implement 2015 Iowa Acts, Senate File 135, which increases the threshold for creating a “committee” from \$750 to \$1,000 and increases the maximum allowable anonymous contribution from \$10 to \$25.

Any interested person may make written suggestions or comments on the proposed amendments no later than December 1, 2015. Such written materials should be directed to Megan Tooker, Iowa Ethics and Campaign Disclosure Board, 510 E. 12th Street, Suite 1A, Des Moines, Iowa 50319; e-mail megan.tooker@iowa.gov; or fax (515)281-4073.

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351](cont'd)

The Iowa Ethics and Campaign Disclosure Board does not intend to grant waivers under the provisions of these rules, other than as allowed under the Board's general rules regarding waivers.

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

These amendments are intended to implement 2015 Iowa Acts, Senate File 135.

The following amendments are proposed.

ITEM 1. Amend subrule 4.1(1) as follows:

4.1(1) *Persons subject to requirement.* Every committee shall file a statement of organization (Form DR-1) within ten days from the date of its organization. The forms shall be either typewritten or printed legibly in black ink.

a. "Committee" defined. "Committee" includes the following:

(1) A "candidate's committee" that is the committee, even if the committee consists only of the candidate, designated by a candidate for a state or local office to receive contributions, make expenditures, or incur debts in excess of ~~\$750~~ \$1,000.

(2) A "political committee" (PAC) that is a committee exceeding the ~~\$750~~ \$1,000 organizational threshold to expressly advocate the nomination, election, or defeat of candidates or to expressly advocate the passage or defeat of a ballot issue. The board shall automatically classify as a political committee any political organization that loses its status as a political party because it fails to meet the requirements of Iowa Code section 43.2. The board shall automatically classify as a political committee any county central committee that operated under the former political party.

(3) A "state statutory political committee" (state party), "county statutory political party" (county central committee), or "city statutory political committee" (city central committee).

(4) A person that wishes to register a committee for purposes of using the short form "paid for by" attribution statement shall file Form DR-SFA pursuant to rule 351—4.11(68A).

b. When organization occurs; financial thresholds. At the latest, organization is construed to have occurred as of the date that the committee first exceeded ~~\$750~~ \$1,000 of financial activity in a calendar year in any of the following categories: contributions received (aggregate of monetary and in-kind contributions); expenditures made; or indebtedness incurred.

c. Permanent organizations temporarily engaging in political activity. The requirement to file the statement of organization applies to an entity that comes under the definition of a "political committee" (PAC) in Iowa Code ~~Supplement~~ section 68A.102(18) as amended by 2015 Iowa Acts, Senate File 135, by receiving contributions, making expenditures, or incurring debts in excess of ~~\$750~~ \$1,000 in any one calendar year for the purpose of expressly advocating the election or defeat of a candidate for public office, or for the purpose of expressly advocating the passage or defeat of a ballot issue. A permanent organization that makes a one-time contribution in excess of ~~\$750~~ \$1,000 may in lieu of filing a statement of organization follow the procedure in rule 351—4.35(68A). A permanent organization that makes loans to a candidate or committee or that is owed debts from a candidate or committee is not deemed to be engaging in political activity requiring registration.

d. Independent expenditure committee. A person that is required to file campaign disclosure reports pursuant to ~~2009~~ Iowa Code ~~Supplement~~ section 68A.404(3) "*a*" as amended by ~~2010~~ Iowa Acts, Senate File 2354, section 3, due to the filing of an independent expenditure statement (Form Ind-Exp-O) shall be referred to as an "independent expenditure committee." An independent expenditure committee, or a sole individual making an independent expenditure by filing Form Ind-Exp-I, is not required to file a statement of organization.

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

4.6(2) *New office sought.* A candidate who filed a statement of organization for one office but eventually seeks another office may file an amended statement of organization to reflect the change in office sought in lieu of dissolving the old committee and organizing a new committee. A candidate filing an amended statement of organization for a new office shall continue to file the required campaign reports regardless of whether the ~~\$750~~ \$1,000 financial filing threshold for the new office has been exceeded. A candidate who has filed a statement of organization for one office and who then exceeds the financial activity threshold as set forth in Iowa Code section 68A.102(5) as amended by 2015 Iowa

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351](cont'd)

Acts, Senate File 135, for a new office shall, within ten days of exceeding the threshold, file either an amended statement of organization disclosing information for the new office sought or organize and register a new committee.

ITEM 3. Amend subrules 4.7(3) and 4.7(4) as follows:

4.7(3) Funds available from prior committee. If funds are available to a candidate's committee from a prior candidacy of that candidate, or to a ballot issue committee from a prior effort on a ballot issue, and the prior candidacy or effort had not exceeded the financial reporting threshold, the carryover balance shall be disclosed by the new committee. The disclosure shall be made on Schedule A - Contributions and shall include the amount of the carryover, the date of the prior election, and the name and address of any source that made contributions to the candidacy or ballot effort that totaled more than ~~\$750~~ \$1,000 during the preceding three calendar years.

4.7(4) Funds available from preballot issue activity. Funds that are raised for an activity that is not included in the definition of a ballot issue in Iowa Code Supplement section 68A.102(1) and that are made available to a subsequent ballot issue committee shall be disclosed by the committee. The disclosure shall be made on Schedule A - Contributions and shall include the amount of the carryover balance, the date of the preballot issue activity, and the name and address of any source that made contributions to the activity that totaled more than ~~\$750~~ \$1,000 during the previous three calendar years.

ITEM 4. Amend subrules 4.11(1) and 4.11(2) as follows:

4.11(1) Persons voluntarily registering a committee. A person that has not exceeded the ~~\$750~~ \$1,000 financial filing threshold may file Form DR-SFA for purposes of using the short form "paid for by" attribution statement under Iowa Code section 68A.405 and rule 351—4.38(68A). A person using the short form "paid for by" attribution statement shall file Form DR-SFA with the board prior to distributing the political material containing the short form "paid for by" attribution statement.

4.11(2) ~~\$750~~ \$1,000 threshold later exceeded. A person filing Form DR-SFA shall not be required to file a statement of organization or be required to file disclosure reports unless the ~~\$750~~ \$1,000 threshold is later exceeded. A person that later exceeds the ~~\$750~~ \$1,000 threshold and that fails to timely file a statement of organization or to timely file disclosure reports may be subject to the appropriate board sanctions as set out by statute and board rule.

ITEM 5. Amend subrule 4.14(4) as follows:

4.14(4) Unitemized contributions and freewill donations. If the committee does not choose to itemize all contributions under the itemization threshold (\$25 for most committees, see Iowa Code Supplement section ~~68A.402(3) "b"~~ 68A.402A(1) "b"), it shall aggregate these contributions and report the aggregate amount as "unitemized contributions." No date received is required to be provided for miscellaneous unitemized contributions. Unitemized contributions may be solicited and received through a freewill donation such as a "fish bowl" or "pass the hat" collection if the collection is in compliance with rule 351—4.30(68A,68B). Unitemized contributions collected through freewill donations (the net amount of the collection after the itemization of those persons whose contributions of more than ~~\$10~~ \$25 in the freewill collection resulted in exceeding the annual itemization threshold) shall be reported by showing the net amount as "unitemized contributions—pass the hat (or can collection or fish bowl, for example) collection." The "date received" to be reported for a freewill donation is the date a representative of the committee takes possession of the proceeds of the collection.

ITEM 6. Amend subrule 4.26(2) as follows:

4.26(2) Transfer of assets for same candidate. A candidate's committee may transfer funds, assets, loans, and debts to a committee established for a different office when the same candidate established both committees. A candidate seeking to transfer funds, assets, loans, or debts under this subrule shall file either an amended statement of organization disclosing information for the new office sought or register a new committee regardless of whether the ~~\$750~~ \$1,000 financial filing threshold for the new office will be exceeded.

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351](cont'd)

ITEM 7. Amend rule 351—4.27(68A) as follows:

351—4.27(68A) Filing of independent expenditure statement. Pursuant to ~~2009 Iowa Code Supplement~~ section 68A.404 as amended by ~~2010 Iowa Acts, Senate File 2354, section 3~~ 2015 Iowa Acts, Senate File 135, any person except a candidate, a committee filing a statement of organization, a federal committee, or an out-of-state committee that makes one or more independent expenditures in excess of ~~\$750~~ \$1,000 in the aggregate shall file Form Ind-Exp-O. A sole individual making one or more independent expenditures in excess of ~~\$750~~ \$1,000 in the aggregate shall file Form Ind-Exp-I. A committee that has registered by filing a statement of organization shall disclose an independent expenditure on the appropriate campaign disclosure report.

4.27(1) Independent expenditure defined. “Independent expenditure” means an expenditure as defined in ~~2009 Iowa Code Supplement~~ section 68A.404(1) as amended by ~~2010 Iowa Acts, Senate File 2354, section 3~~ 2015 Iowa Acts, Senate File 135.

4.27(2) Independent expenditure reporting. When applicable under ~~2009 Iowa Code Supplement~~ section 68A.404 as amended by ~~2010 Iowa Acts, Senate File 2354, section 3~~, and rule 351—4.27(68A), Form Ind-Exp-O shall be filed by a person and Form Ind-Exp-I shall be filed by a sole individual. Both forms shall be in a format that will enable a person or sole individual making an independent expenditure to comply with all of the reporting requirements in ~~2009 Iowa Code Supplement~~ section 68A.404 as amended by ~~2010 Iowa Acts, Senate File 2354, section 3~~ 2015 Iowa Acts, Senate File 135.

4.27(3) Place of filing. Form Ind-Exp-O and Form Ind-Exp-I shall be filed with the board electronically via the board’s Web site at www.iowa.gov/ethics.

4.27(4) Time of filing. Form Ind-Exp-O or Form Ind-Exp-I shall be filed within 48 hours of the person’s or sole individual’s making an independent expenditure exceeding ~~\$750~~ \$1,000 in the aggregate or within 48 hours of disseminating the communication to its intended audience, whichever is earlier. An independent expenditure is deemed made at the time that the cost is incurred regardless of whether or not the costs for the independent expenditure have been billed.

4.27(5) Failure to file. The failure to timely file either Form Ind-Exp-O or Form Ind-Exp-I shall be subject to the imposition of civil penalties pursuant to ~~351—subrule 4.59(7)~~.

4.27(6) Attribution statement applicable. Any person that makes an independent expenditure in any amount shall comply with the appropriate “paid for by” attribution statement pursuant to ~~2009 Iowa Code Supplement~~ section 68A.405 as amended by ~~2010 Iowa Acts, Senate File 2354, section 4, and by 2010 Iowa Acts, Senate File 2195, section 7~~, and rule 351—4.38(68A).

This rule is intended to implement ~~2009 Iowa Code Supplement~~ section 68A.404 as amended by ~~2010 Iowa Acts, Senate File 2354, section 3~~ 2015 Iowa Acts, Senate File 135.

ITEM 8. Amend subrules 4.30(1), 4.30(2) and 4.30(4) as follows:

4.30(1) Anonymous contributions in excess of \$10 \$25 prohibited. No person shall make a contribution in excess of ~~\$10~~ \$25 to a committee without providing the person’s name and address to the committee. The committee shall not maintain in any campaign account funds in excess of ~~\$10~~ \$25 that cannot be accounted for and reconciled with the committee’s disclosure reports.

4.30(2) Escheat to the state. Any contribution in excess of ~~\$10~~ \$25 from an unknown source or campaign funds in excess of ~~\$10~~ \$25 that cannot be accounted for and reconciled shall escheat to the state of Iowa as required by Iowa Code section 68A.501 as amended by ~~2007 Iowa Acts, Senate File 39, section 8~~ 2015 Iowa Acts, Senate File 135. A committee required to escheat shall escheat such funds by depositing the funds into the committee’s campaign account and issuing a committee check to the general fund in the same amount. The committee check shall be sent to the board office at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319, for transmittal to the office of treasurer of state.

4.30(4) Notice at fund-raising event. Pursuant to Iowa Code ~~Supplement~~ section 68A.501 as amended by 2015 Iowa Acts, Senate File 135, a person requested to make a contribution at a fund-raising event shall be advised that it is illegal to make a contribution in excess of ~~\$10~~ \$25 unless the person making the contribution also provides the person’s name and address. Notice of the requirement to provide a person’s name and address for a contribution in excess of ~~\$10~~ \$25 may be made orally or in a written statement that is displayed at the fund-raising event.

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351](cont'd)

ITEM 9. Amend subrule 4.31(3) as follows:

4.31(3) *Registering a committee.* A trust, except for a living or revocable trust, that raises or spends more than ~~\$750~~ \$1,000 for campaign activities shall register a political committee (PAC) and shall file disclosure reports. A trust, except for a living or revocable trust, that makes a one-time contribution in excess of ~~\$750~~ \$1,000 may file Form DR-OTC in lieu of filing a statement of organization and filing disclosure reports.

ITEM 10. Amend rule 351—4.35(68A) as follows:

351—4.35(68A) Permanent organizations forming temporary political committees; one-time contributor filing Form DR-OTC. Pursuant to Iowa Code section 68A.402(9), a permanent organization temporarily engaging in activity that exceeds the ~~\$750~~ \$1,000 financial filing threshold described in rule 351—4.1(68A,68B) is required to organize and register a political committee (PAC), file disclosure reports, and, upon completion of activity, file a notice of dissolution. A permanent organization that is temporarily a political committee shall comply with all of the campaign laws in Iowa Code chapter 68A and this chapter. A permanent organization that makes loans to a candidate or committee or that is owed debts from a candidate or committee is not deemed to be engaging in political activity requiring registration.

4.35(1) *Form DR-OTC.* A permanent organization that makes a one-time contribution in excess of ~~\$750~~ \$1,000 to a committee may, in lieu of filing a statement of organization, disclosure reports, and a notice of dissolution, file Form DR-OTC. The following information shall be disclosed on Form DR-OTC:

a. to f. No change.

A permanent organization that makes more than one contribution is not eligible to file Form DR-OTC and is required to file a statement of organization, file disclosure reports, and file a notice of dissolution.

4.35(2) *Place of filing.* Form DR-OTC shall be filed with the board at 510 East 12th Street, Suite 1A, Des Moines, Iowa 50319, filed by fax at (515)281-4073, or filed electronically using the board's Web site at www.iowa.gov/ethics.

4.35(3) *Time of filing.* Form DR-OTC shall be filed with the board within ten days after the one-time contribution in excess of ~~\$750~~ \$1,000 is made. The form must be physically received by the board or, if mailed, must bear a United States Postal Service postmark dated on or before the report due date. A faxed or electronically filed Form DR-OTC must be submitted on or before 11:59 p.m. of the tenth day after the organization of the committee is required. If the tenth day falls on a Saturday, Sunday, or holiday on which the board office is closed, the filing deadline is extended to the next working day when the board office is open.

4.35(4) *Failure to register.* If the board discovers that a permanent organization has become subject to the provisions of Iowa Code ~~Supplement~~ chapter 68A but did not timely file a statement of organization or file Form DR-OTC, as applicable, the permanent organization is subject to the possible imposition of board sanctions.

4.35(5) *Partial refund of contribution.* A committee that receives a contribution from a permanent organization that causes the organization to become subject to the provisions of Iowa Code ~~Supplement~~ chapter 68A may refund all or part of a contribution to the organization so as to reduce the contribution to ~~\$750~~ \$1,000 or less and remove the organization's filing obligations.

This rule is intended to implement Iowa Code sections 68A.102(18) and 68A.402.

ITEM 11. Amend paragraph **4.37(2)“a”** as follows:

a. A ledger or similar record-keeping device which details all contributions received by the committee. This record shall include the name and address of each person making a contribution in excess of ~~\$10~~ \$25, with the date and amount of the contribution. In lieu of or in addition to a ledger, the committee may record contributions received through a receipt book or other method of individually documenting the contributions, such as by making and keeping copies of the contribution checks.

ETHICS AND CAMPAIGN DISCLOSURE BOARD, IOWA[351](cont'd)

ITEM 12. Amend subrule 4.59(8) as follows:

4.59(8) Form DR-OTC assessment. A permanent organization that has not previously made a contribution in excess of \$750 \$1,000 and that fails to file Form DR-OTC within ten days of notice to do so by the board shall be assessed a \$20 civil penalty. A permanent organization that has previously made a contribution in excess of \$750 \$1,000 and that fails to file Form DR-OTC within ten days of the date on which the contribution check is issued shall be assessed a \$20 civil penalty.

ARC 2242C**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 and 2015 Iowa Acts, Senate File 505, section 12(24), the Department of Human Services proposes to amend Chapter 36, “Facility Assessments,” Chapter 74, “Iowa Health and Wellness Plan,” Chapter 75, “Conditions of Eligibility,” Chapter 77, “Conditions of Participation for Providers of Medical and Remedial Care,” Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services,” Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” Chapter 81, “Nursing Facilities,” Chapter 82, “Intermediate Care Facilities for Persons with an Intellectual Disability,” Chapter 83, “Medicaid Waiver Services,” Chapter 85, “Services in Psychiatric Institutions,” and Chapter 90, “Targeted Case Management,” and to rescind Chapter 92, “IowaCare,” Iowa Administrative Code.

Iowa’s Medicaid program is evolving to create a single system of care to address the health care needs of the whole person, including physical health, behavioral health, and long-term care services and supports. This initiative will deliver quality, patient-centered care to improve the overall health of the Medicaid population and will lead to a more predictable and sustainable budget.

Beginning January 1, 2016, HAWK-I members, Iowa Health and Wellness members, as well as the majority of Medicaid members will have their services coordinated through a managed care organization. Medicaid members who will not be served by a managed care organization include members of the Health Insurance Premium Payment (HIPP) Program, Medically Needy Program, or Programs for All-Inclusive Care for the Elderly (PACE); persons who are determined to be presumptively eligible for Medicaid services; and members who participate in the Medicare Savings Program; and members who are American Indian or Alaska Natives who do not volunteer to be served through a managed care organization in this program.

This Notice of Intended Action is one of two rule makings that the Department is proposing to implement the Governor’s Medicaid Modernization Initiative as referenced in 2015 Iowa Acts, Senate File 505, section 12(24). The other rule making is published herein under Notice of Intended Action as **ARC 2241C**.

The proposed amendments in this rule making:

- Clarify coverage under the Marketplace Choice Plan, as this coverage will be absorbed under the Iowa Health and Wellness Plan (IHAWP) and will be referred to as “Wellness Plan” moving forward.
- Clarify the process by which an IHAWP member claims a “hardship exemption,” indicating that payment of the monthly contribution for the Wellness Plan will be a financial hardship.
- Remove references to the Iowa Plan for Behavioral Health.
- Rescind outdated subrules regarding provider qualifications, prior to December 31, 2006, for home- and community-based services (HCBS) provided in residential care facilities.
- Remove outdated references to “mental retardation” and replace them with “intellectual disability.”

HUMAN SERVICES DEPARTMENT[441](cont'd)

- Replace outdated references to “comprehensive functional assessment tool” for the intellectual disability waiver with “Supports Intensity Scale (SIS) assessment.”
- Remove outdated references to the Iowa Foundation for Medical Care (IFMC) and replace them with references to the IME medical services unit.
- Add the managed care organizations’ role or responsibility in delivery and payment of Medicaid-covered services.
- Clarify the process for provider notification of incident reports for members enrolled with a managed care organization.
- Add a new service definition of and reimbursement methodology and record requirements for child care medical services.
- Remove references to accountable care organizations.
- Remove outdated references to average wholesale price (AWP) for drug reimbursement and state maximum allowable cost (SMAC) reimbursement for generic drugs.
- Clarify that requests for prior authorization go through the managed care organization.
- Clarify the process for drug authorization and remove outdated language related to the process.
- Remove references to the MediPASS Program.
- Add definitions of level of care criteria for facilities and the HCBS waivers.
- Remove the service plan as a requirement for the HCBS waiver and state plan HCBS eligibility determinations.
- Rescind rules relating to IowaCare.

Any interested person may make written comments on the proposed amendments on or before December 1, 2015. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, Fifth Floor, 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.

The Department of Human Services will hold a public hearing in each of the Department’s service areas. The purpose of the public hearings is to receive oral or written comments on these proposed amendments regarding the implementation of the Governor’s Medicaid Modernization Initiative. At the hearings, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments.

Public hearings will be held at the following locations and times:

Cedar Rapids Service Area Cedar Rapids Public Library Whipple Auditorium 450 5th Avenue SE Cedar Rapids, Iowa	Wednesday, December 2, 2015 9 to 11 a.m.
Eastern Service Area Administration Building Boardroom 600 W. 4th Street Davenport, Iowa	Wednesday, December 2, 2015 1 to 3 p.m.
Des Moines Service Area Polk County River Place Conference Room 1-1A 2309 Euclid Avenue Des Moines, Iowa	Friday, December 4, 2015 9 to 11 a.m.
Northern Service Area Black Hawk County DHS, Pinecrest Office Building Conference Room 201 1407 Independence Avenue Waterloo, Iowa	Friday, December 4, 2015 1 to 3 p.m.

HUMAN SERVICES DEPARTMENT[441](cont'd)

Western Service Area
Council Bluffs Public Library
200 Pearl Street
Council Bluffs, Iowa

Friday, December 4, 2015
2 to 4 p.m.

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, there will be a reduction in the staff of the current vendors providing administrative support to the current Medicaid program; however, the managed care organizations will be hiring new staff to accommodate their new line of business in Iowa.

These amendments are intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12(24).

The following amendments are proposed.

ITEM 1. Amend **441—Chapter 36**, division I title, as follows:

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR ~~THE MENTALLY RETARDED~~ PERSONS WITH AN INTELLECTUAL DISABILITY

ITEM 2. Amend rule 441—36.1(249A) as follows:

441—36.1(249A) Assessment of fee. Intermediate care facilities for ~~the mentally retarded~~ persons with an intellectual disability (ICFs/MR ID) licensed in Iowa under 481—Chapter 64 shall pay a monthly fee to the department. Effective January 1, 2008, the fee shall equal 5.5 percent of the total revenue of the facility for the facility's preceding fiscal year divided by the number of months of facility operation during the preceding fiscal year.

ITEM 3. Amend subrule 36.2(3) as follows:

36.2(3) ~~The department shall deduct the monthly amount due from medical assistance payments to the facility. The department shall also deduct from medical assistance payments any additional amount due for past months as a result of an adjustment to the assessment. ICFs/ID shall pay the monthly amount due to the department.~~

ITEM 4. Amend subrule 36.3(1) as follows:

36.3(1) Any licensed ICF/MR ID in Iowa that is not certified to participate in the Medicaid program shall submit Form 470-0030, Financial and Statistical Report, as required for participating facilities by rule 441—82.5(249A), for purposes of determining the amount of the assessment. The department may audit and adjust the reports submitted, as provided for participating facilities in 441—subrules 82.5(10) and 82.17(1).

ITEM 5. Rescind the definition of "Accountable care organization" in rule **441—74.1(249A,85GA,SF446)**.

ITEM 6. Adopt the following new definition of "Managed care organization" in rule **441—74.1(249A,85GA,SF446)**:

"*Managed care organization*" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

ITEM 7. Amend subparagraph **74.11(2)"c"(5)** as follows:

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

HUMAN SERVICES DEPARTMENT[441](cont'd)

ITEM 8. Amend paragraph **74.11(4)“a”** as follows:

a. A Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member’s overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dental provider consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

ITEM 9. Amend subrule 74.12(1) as follows:

74.12(1) Iowa wellness plan services. Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be a medically exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

a. No change.

~~*b.* The Iowa wellness plan provider network shall include all providers enrolled in the medical assistance program, including all participating accountable care organizations.~~

~~*c.* Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88. In addition to reimbursement for managed care pursuant to 441—Chapter 88, the department may provide care coordination fees, performance incentive payments, or shared savings arrangements for medical homes and accountable care organizations serving members enrolled in the Iowa wellness plan.~~

~~*d.* When the member does not choose a primary medical provider, the department shall assign the member to a primary medical provider in accordance with the Medicaid managed health care mandatory enrollment provisions specified in 441—subrule 88.3(7) for mandatory enrollment counties and in accordance with quality data available to the department.~~

~~*e.* Dental services shall be provided through a contract with one or more commercial dental plans. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.~~

ITEM 10. Amend subrule 74.12(2) as follows:

74.12(2) Marketplace choice plan services. At the department’s discretion, Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level ~~shall~~ may be enrolled in a marketplace choice plan unless the member is determined by the department to be a medically exempt individual. ~~Marketplace~~ At the department’s discretion, ~~marketplace~~ marketplace choice coverage ~~shall~~ may be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will be provided by the medical assistance program. ~~Individuals who have been determined eligible for the marketplace choice plan, but who have not yet been enrolled in a marketplace choice plan, shall receive fee-for-service coverage under the Iowa wellness plan until they choose or are assigned to a marketplace choice plan.~~

a. to e. No change.

ITEM 11. Amend subrule 74.13(1) as follows:

74.13(1) Claims for services not provided by a qualified health plan. Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member’s qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80 or to the member’s Medicaid managed care organization.

ITEM 12. Amend subrule 74.13(2) as follows:

74.13(2) Payment for services not provided by a qualified health plan. Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member’s qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided

HUMAN SERVICES DEPARTMENT[441](cont'd)

in a contract between the department or the member's Medicaid managed care organization and the provider.

ITEM 13. Rescind and reserve rule **441—74.15(249A,85GA,ch138)**.

ITEM 14. Amend paragraph **75.21(10)“b”** as follows:

b. For individual health plans, the client shall complete HIPP ~~Individual~~ Private Policy Review, Form 470-3017, for the review.

ITEM 15. Amend subparagraph **75.21(12)“a”(3)** as follows:

(3) The health plan is no longer available to the family (e.g., the employer ~~drops~~ no longer provides health insurance coverage or the policy is terminated by the insurance company).

ITEM 16. Amend rule **441—75.25(249A)**, definition of “Noncovered Medicaid services,” as follows:

“*Noncovered Medicaid services*” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

ITEM 17. Amend subrule 75.28(7) as follows:

75.28(7) Estate recovery. Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.5(2)“d.” 249A.53(2)“d.” The classification of the debt is defined at Iowa Code section 633.425(7).

a. *Definition of estate Definitions.*

“*Capitated payment/rate*” means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

“*Estate.*” For the purpose of this subrule, the “estate” of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

b. to f. No change.

g. *Waiving the collection of the debt.*

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. No change.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, “income” and “resources” shall be defined as being under the family ~~medical assistance~~ investment program.

HUMAN SERVICES DEPARTMENT[441](cont'd)

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section ~~633.425~~ 249A.53(2).

(3) No change.

h. to k. No change.

ITEM 18. Rescind and reserve rule **441—75.30(249A)**.

ITEM 19. Amend rule 441—77.10(249A) as follows:

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate ~~in the program~~ provided that the dealers are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

ITEM 20. Amend rule 441—77.12(249A) as follows:

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is ~~enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.~~ accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC).

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

ITEM 21. Amend rule 441—77.25(249A), introductory paragraph, as follows:

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall ~~be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health~~ and meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

ITEM 22. Adopt the following new definition of “Managed care organization” in subrule **77.25(1)**:
 “*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 23. Amend subparagraph **77.25(3)“b”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

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ITEM 24. Rescind paragraph **77.25(6)“j.”**

ITEM 25. Rescind paragraph **77.25(7)“g.”**

ITEM 26. Rescind and reserve subrule **77.25(10)**.

ITEM 27. Amend subparagraph **77.30(18)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 28. Amend subparagraph **77.33(22)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 29. Amend subparagraph **77.34(14)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 30. Amend subparagraph **77.37(8)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 31. Amend subparagraph **77.37(23)“d”(4)** as follows:

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on ~~Form 470-3273, Mental Retardation Functional Assessment Tool~~ the Supports Intensity Scale® (SIS) assessment.

ITEM 32. Amend subparagraph **77.37(23)“d”(6)** as follows:

- (6) The individual service plan shall be revised when any of the following occur:
1. and 2. No change.
 3. Changes have occurred in the identified service needs of the child, as listed on ~~Form 470-3273, Mental Retardation Functional Assessment Tool~~ the Supports Intensity Scale® (SIS) assessment.

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4. No change.

ITEM 33. Amend subparagraph **77.39(6)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 34. Amend subparagraph **77.41(12)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 35. Amend subparagraph **77.46(1)“d”(4)** as follows:

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 36. Amend subparagraph **77.47(1)“d”(2)** as follows:

(2) Have a direct agreement with ~~the~~ an Iowa Medicaid managed ~~behavioral health care~~ behavioral health care organization to provide health home services for members with SMI or SED;

ITEM 37. Rescind rule 441—77.51(249A) and adopt the following **new** rule in lieu thereof:

441—77.51(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served. Nursing services must be provided.

ITEM 38. Amend paragraph **78.1(1)“g”** as follows:

g. Charges for surgical procedures on the “Outpatient/Same Day Surgery List” produced by ~~the Iowa Foundation for Medical Care~~ IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital’s utilization review department prior to the patient’s admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall

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be developed by the ~~Iowa Foundation for Medical Care~~, IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The ~~Iowa Foundation for Medical Care~~ IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

ITEM 39. Amend subrule 78.1(19) as follows:

78.1(19) Preprocedure review by the ~~Iowa Foundation for Medical Care (IFMC)~~ IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the ~~IFMC~~ IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the ~~published~~ criteria established by the ~~IFMC~~ IME medical services unit and the department. If not so approved by the ~~IFMC~~ IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from ~~IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices~~ the IME medical services unit.

The "~~Preprocedure Surgical Review List~~" shall be ~~published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1)"e.")~~

ITEM 40. Amend paragraph **78.1(20)"a"** as follows:

a. Payment will be made only for the following organ and tissue transplant services:

(1) to (3) No change.

(4) Liver transplants for persons with extrahepatic biliary artesia atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. (Cross-reference 78.1(19) and 78.28(1)"f.")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the ~~Iowa Medicaid enterprise~~ IME medical services ~~prior authorization~~ unit. (Cross-reference 78.1(19) and 78.28(1)"f.") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. (Cross-reference 78.1(19) and 78.28(1)"f.") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

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- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. (Cross-reference 78.1(19) and 78.28(1)“f.”)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

ITEM 41. Amend subrule 78.2(5) as follows:

78.2(5) Nonprescription drugs.

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
 Acetaminophen elixir 160 mg/5 ml
 Acetaminophen solution 100 mg/ml
 Acetaminophen suppositories 120 mg
 Artificial tears ophthalmic solution
 Artificial tears ophthalmic ointment
 Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
 Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
 Aspirin tablets, buffered 325 mg
 Bacitracin ointment 500 units/gm
 Benzoyl peroxide 5%, gel, lotion
 Benzoyl peroxide 10%, gel, lotion
 Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
 Calcium carbonate suspension 1250 mg/5 ml
 Calcium carbonate tablets 600 mg
 Calcium carbonate-vitamin D tablets 500 mg-200 units
 Calcium carbonate-vitamin D tablets 600 mg-200 units
 Calcium citrate tablets 950 mg (200 mg elemental calcium)
 Calcium gluconate tablets 650 mg
 Calcium lactate tablets 650 mg
 Cetirizine hydrochloride liquid 1 mg/ml
 Cetirizine hydrochloride tablets 5 mg
 Cetirizine hydrochloride tablets 10 mg
 Chlorpheniramine maleate tablets 4 mg
 Clotrimazole vaginal cream 1%
 Diphenhydramine hydrochloride capsules 25 mg
 Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
 Epinephrine racemic solution 2.25%
 Ferrous sulfate tablets 325 mg
 Ferrous sulfate elixir 220 mg/5 ml
 Ferrous sulfate drops 75 mg/0.6 ml
 Ferrous gluconate tablets 325 mg
 Ferrous fumarate tablets 325 mg
 Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
 Ibuprofen suspension 100 mg/5 ml
 Ibuprofen tablets 200 mg
 Insulin
 Lactic acid (ammonium lactate) lotion 12%
 Loperamide hydrochloride liquid 1 mg/5 ml

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Loperamide hydrochloride tablets 2 mg
 Loratadine syrup 5 mg/5 ml
 Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
 Magnesium oxide tablets 400 mg
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Multiple vitamin and mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

ITEM 42. Amend subrule 78.3(13) as follows:

78.3(13) Payment for patients in acute hospital beds who are determined by ~~IFMC~~ the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by ~~IFMC~~ the IME medical services unit that the lower level of care is required or (b) for the days ~~IFMC~~ the IME medical services unit determines in an outlier review that the lower level of care was required.

ITEM 43. Amend subrule 78.3(14) as follows:

78.3(14) Payment for patients in acute hospital beds who are determined by ~~IFMC~~ the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph

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81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by ~~IFMC~~ the IME medical services unit that the lower level of care is required or (b) for the days ~~IFMC~~ the IME medical services unit determines in an outlier review that the lower level of care was required.

ITEM 44. Amend subrule 78.3(15) as follows:

~~78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor’s office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.” normally done and billed on an outpatient hospital basis are subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.~~

ITEM 45. Amend subrule 78.3(18) as follows:

~~78.3(18) Preprocedure review by the IFMC~~ IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices the IME medical services unit. (Cross-reference 78.28(5))

ITEM 46. Amend subrule **78.12(1)**, definition of “Licensed practitioner of the healing arts,” as follows:

“Licensed practitioner of the healing arts” or “LPHA,” as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

- ~~1. Is licensed by the applicable state authority for that profession;~~
- ~~2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and~~
- ~~3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.~~

ITEM 47. Adopt the following **new** definition of “Managed care organization” in subrule **78.12(1)**:

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

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ITEM 48. Amend subparagraph **78.12(4)“b”(2)** as follows:

(2) ~~Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.~~

ITEM 49. Amend paragraph **78.26(4)“c”** as follows:

c. ~~Preprocedure review by the Iowa Foundation for Medical Care (IFMC) IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices the IME medical services unit. (Cross-reference 78.28(6))~~

ITEM 50. Amend rule 441—78.27(249A), introductory paragraph, as follows:

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan ~~for Behavioral Health Medicaid enterprise.~~

ITEM 51. Adopt the following **new** definition of “Managed care organization” in subrule **78.27(1)**:
“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 52. Amend paragraph **78.27(2)“d”** as follows:

d. *Needs assessment.* The member’s case manager or integrated health home care coordinator has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise IME medical services unit ~~or the Iowa Plan for Behavioral Health contractor~~ has determined that the member is in need of home- and community-based habilitation services. ~~A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service.~~ The designated case manager or integrated health home care coordinator shall:

(1) and (2) No change.

ITEM 53. Amend paragraph **78.27(2)“e”** as follows:

e. *Plan for service.* The department ~~or the Iowa Plan for Behavioral Health contractor~~ has approved the member’s comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS ~~or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor~~ shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.

(1) to (3) No change.

ITEM 54. Rescind paragraph **78.27(2)“f.”**

ITEM 55. Amend subrule 78.27(3) as follows:

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the Iowa Plan ~~for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason~~ IME medical services unit. The department ~~or the Iowa Plan for Behavioral Health contractor~~ shall issue a notice of decision to the applicant when financial eligibility, ~~determination of and~~ needs-based eligibility, ~~and approval of the comprehensive service plan or treatment plan~~ determinations have been completed.

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ITEM 56. Amend subparagraph **78.27(4)“a”(9)** as follows:

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the ~~Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health,~~ IME medical services unit in the individualized services information system ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

ITEM 57. Amend subparagraph **78.27(4)“a”(10)** as follows:

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the ~~Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise~~ IME medical services unit for members not eligible to enroll in the ~~Iowa Plan for Behavioral Health,~~ a managed care organization in the ~~individualized services information system~~ ISIS before the implementation of services. Services provided before the approval date are not payable.

ITEM 58. Amend paragraph **78.27(4)“e”** as follows:

e. Plan approval.

~~(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.~~

~~(2) For members who are not Iowa Plan eligible, services~~ Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) “e.”

ITEM 59. Amend subrule 78.27(11) as follows:

78.27(11) Adverse service actions.

~~a. Denial.~~ Services shall be denied when the department ~~or the Iowa Plan for Behavioral Health contractor~~ determines that:

(1) to (5) No change.

~~b. Reduction.~~ A particular home- and community-based habilitation service may be reduced when the department ~~or the Iowa Plan for Behavioral Health contractor~~ determines that continued provision of service at its current level is not necessary.

~~c. Termination.~~ A particular home- and community-based habilitation service may be terminated when the department ~~or the Iowa Plan for Behavioral Health contractor~~ determines that:

(1) to (4) No change.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department ~~or the Iowa Plan for Behavioral Health contractor~~ will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) to (9) No change.

d. Appeal rights.

~~(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.~~

(2) The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

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ITEM 60. Amend paragraph **78.28(1)“f”** as follows:

f. Preprocedure review by the ~~Iowa Foundation for Medical Care (IFMC)~~ IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by ~~IFMC~~ the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the ~~published~~ criteria established by the department and the ~~IFMC~~ IME medical services unit. If not so approved by the ~~IFMC~~ IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from ~~IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices~~ the IME medical services unit.

~~The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))~~

ITEM 61. Amend paragraph **78.28(5)“b”** as follows:

b. All inpatient hospital admissions are subject to ~~preadmission~~ retrospective review. Payment for inpatient hospital admissions ~~which are retrospectively reviewed~~ is approved when ~~it the claim~~ meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals IME medical services unit. Criteria are available from ~~IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices~~ the IME medical services unit. (Cross-reference 441—78.3(249A))

ITEM 62. Amend paragraph **78.28(5)“c”** as follows:

c. Preprocedure review by the ~~IFMC~~ IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the ~~IFMC~~ IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department and ~~IFMC~~. The criteria are available from ~~IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices~~ the IME medical services unit.

ITEM 63. Adopt the following new subrule 78.28(8):

78.28(8) Nursing, personal care, or psychosocial services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service per discipline.

ITEM 64. Amend subrule 78.31(1) as follows:

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. to n. No change.

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ITEM 65. Amend rule 441—78.33(249A) as follows:

441—78.33(249A) Case management services.

~~78.33(1)~~ Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

a. ~~1.~~ Members who are 18 years of age or over and have a primary diagnosis of ~~mental retardation~~ intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. ~~2.~~ Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

~~78.33(2)~~ Notwithstanding ~~subrule 78.33(1), payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.~~

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

ITEM 66. Adopt the following new rule 441—78.57(249A):

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills.

78.57(3) Psychosocial services are those services that teach pro-social skills and reinforce positive interactions. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(5) Requirements.

a. Nursing, personal care, or psychosocial services shall be ordered in writing.

b. Nursing, personal care, or psychosocial services shall be authorized by the department or the department's designated review agent prior to payment.

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c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The treatment plan shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
 - (2) Type of service to be rendered and the treatment modalities being used.
 - (3) Frequency of the services.
 - (4) Assistance devices to be used.
 - (5) Date on which services were initiated.
 - (6) Progress of member in response to treatment.
 - (7) Medical supplies to be furnished.
 - (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of instability.
 9. Date of last episode of acute recurrence of illness or symptoms.
 10. Medications.
 - (9) Discipline of the person providing the service.
 - (10) Certification period.
 - (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
 - (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.
- 78.57(6)** Nursing, personal care, and psychosocial services do not include:
- a. Services provided to members aged 21 and older.
 - b. Services that require prior authorizations that are provided without regard to the prior authorization process.
 - c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
 - d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
 - e. Transportation services.
 - f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

ITEM 67. Amend rule 441—79.1(249A), introductory paragraph, as follows:

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept

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reimbursement based upon the department's methodology without making any additional charge to the member.

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

ITEM 68. Amend subrule **79.1(2)**, provider categories of "Behavioral health intervention," "Federally qualified health centers," "Psychiatric medical institutions for children" and "Rural health clinics," as follows:

Provider category	Basis of reimbursement	Upper limit
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/13.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A) <u>Chapter 73</u>	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Provider-specific fee Fee schedule as determined by the Iowa Plan for Behavioral Health contractor	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A) <u>Chapter 73</u>	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.

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ITEM 69. Adopt the following **new** provider categories in alphabetical order in subrule **79.1(2)**:

Provider category	Basis of reimbursement	Upper limit
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.

ITEM 70. Amend subrule 79.1(8) as follows:

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. ~~Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.~~

~~a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "c," whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:~~

~~(1) The estimated acquisition cost, defined:~~

~~1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i"; or~~

~~2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(4) The submitted charge, representing the provider's usual and customary charge for the drug.~~

~~b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "d," whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:~~

~~(1) The estimated acquisition cost, defined:~~

~~1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i"; or~~

~~2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(2) The submitted charge, representing the provider's usual and customary charge for the drug.~~

~~c. a. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:~~

~~(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) "k g," plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "j f."~~

~~(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "j f."~~

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(3) The submitted charge, representing the provider's usual and customary charge for the drug.

~~d. b.~~ Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) "~~k g,~~" plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "~~j f,~~"

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

~~e. c.~~ No payment shall be made for sales tax.

~~f. d.~~ All hospitals that wish to administer vaccines which are available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

~~g.~~ Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "~~e,~~" whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8) "~~a~~" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

~~h. e.~~ An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription pursuant to paragraphs 79.1(8) "~~a~~" and "~~b~~" for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

~~i.~~ Rescinded IAB 6/11/14, effective 8/1/14.

~~j. f.~~ The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.

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

~~l.~~ For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

~~m.~~ Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

~~n. h.~~ Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).

ITEM 71. Amend paragraph **79.1(16)"b"** as follows:

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) and (2) No change.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan

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~~contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.~~

~~(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.~~

~~(5) Substance abuse services for members enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.~~

ITEM 72. Amend subparagraph **79.1(16)“r”(3)** as follows:

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

1. For members ~~not participating in the MediPASS program~~ who were referred to the emergency room by appropriate medical personnel ~~and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician,~~ payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

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

3. ~~For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.~~

ITEM 73. Amend subparagraph **79.1(24)“d”(2)** as follows:

(2) For dates of services ~~on or after~~ from January 1, 2014, through December 31, 2015, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) “b,” the Iowa Plan for Behavioral Health contractor shall reduce the provider’s reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

ITEM 74. Adopt the following **new** subparagraph **79.1(24)“d”(3)**:

(3) For dates of services on or after January 1, 2016, providers shall be reimbursed by fee schedule.

ITEM 75. Amend paragraph **79.1(25)“b”** as follows:

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology ~~established by the Medicaid program’s managed care contractor for mental health services and~~ approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology ~~established by the Medicaid program’s managed care contractor for mental health services,~~ the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

ITEM 76. Adopt the following **new** subparagraph **79.3(2)“d”(43)**:

(43) Child care medical services:

1. Plan of care.
2. Certification and recertification.
3. Service notes or narratives.
4. Physician orders or medical orders.

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5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature.)

ITEM 77. Amend rule 441—79.8(249A), introductory paragraph, as follows:

441—79.8(249A) Requests for prior authorization. ~~When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.~~ This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

ITEM 78. Amend paragraph **79.8(1)“a”** as follows:

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. ~~Requests for prior authorization for drugs may also be made by telephone~~ must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

ITEM 79. Amend subrule 79.8(7) as follows:

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

- ~~*a.*~~ (1) The conditions for payment outlined in the provider manual with reference to coverage and duration.
- ~~*b.*~~ (2) The determination made by the Medicare program unless specifically stated differently in state law or rule.
- ~~*c.*~~ (3) The recommendation to the department from the appropriate advisory committee.
- ~~*d.*~~ (4) Whether there are other less expensive procedures which are covered and which would be as effective.
- ~~*e.*~~ (5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

ITEM 80. Amend subrule 79.10(5) as follows:

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter ~~88~~ 73.

ITEM 81. Amend subrule 79.11(6) as follows:

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter ~~88~~ 73.

ITEM 82. Amend subrule 79.14(1), introductory paragraph, as follows:

79.14(1) Application request. ~~Iowa Medicaid providers other than managed care organizations and Medicaid fiscal agents,~~ including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site. Managed care organizations and fiscal agents are exempt from completing an application.

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ITEM 83. Adopt the following **new** definitions of “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—81.1(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 84. Amend rule 441—81.5(249A), introductory paragraph, as follows:

441—81.5(249A) Discharge and transfer. (See ~~subrules 81.13(2)“a” and paragraph 81.13(6)“c.”~~)

ITEM 85. Amend subrule 81.5(1) as follows:

81.5(1) Notice. When a ~~public assistance recipient~~ Medicaid member requests transfer or discharge, or another person requests this for the ~~recipient member~~, the administrator shall promptly notify ~~the local office of~~ the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

ITEM 86. Amend subrule 81.7(1) as follows:

81.7(1) Level of care. The IME medical services unit shall review Medicaid members’ need ~~of~~ for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member’s need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

ITEM 87. Amend rule 441—81.12(249A) as follows:

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department and the department’s contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the ~~local office of the department~~ resident’s managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) “a.”

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ITEM 88. Amend subparagraph **81.13(6)“a”(4)** as follows:

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident's case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
2. and 3. No change.

ITEM 89. Amend subparagraph **81.13(9)“d”(2)** as follows:

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

ITEM 90. Amend subrule 81.14(2) as follows:

81.14(2) *Audit of proper billing and handling of patient funds.*

a. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals, ~~or~~ and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals ~~or~~ and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. to f. No change.

ITEM 91. Amend rule 441—81.20(249A), introductory paragraph, as follows:

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

ITEM 92. Adopt the following new definitions of “Intermediate care facility for persons with an intellectual disability (ICF/ID),” “Intermediate care facility for persons with an intellectual disability level of care” and “Managed care organization” in rule **441—82.1(249A)**:

“*Intermediate care facility for persons with an intellectual disability (ICF/ID)*” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

HUMAN SERVICES DEPARTMENT[441](cont'd)

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 93. Amend rule 441—82.2(249A), introductory paragraph, as follows:

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as a ~~hospital, nursing facility, or an intermediate care facility~~ for persons with an intellectual disability by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

ITEM 94. Amend subparagraph **82.2(4)“c”(2)** as follows:

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. For those clients enrolled with a managed care organization, the client’s case manager shall participate as appropriate and as allowed by the client. Participation by the client, the client’s parents (if the client is a minor), or the client’s legal guardian is required unless that participation is unobtainable or inappropriate.

ITEM 95. Amend subrule 82.6(3) as follows:

82.6(3) Certification statement. Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility shall continue as long as a valid need for the care exists.

ITEM 96. Amend paragraph **82.7(2)“b”** as follows:

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.7(3), the eligible person, or the person’s representative, is free to seek placement in the facility of the person’s or the person’s representative’s choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

ITEM 97. Amend subrule 82.7(3) as follows:

82.7(3) Approval of level of care. Medicaid payment shall be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit. ~~The IME medical services unit shall review ICF/ID admissions and transfers only when documentation is provided which verifies a referral from targeted case management that includes an approval by the department.~~

ITEM 98. Amend rule 441—82.8(249A) as follows:

441—82.8(249A) Determination of need for continued stay. ~~Certification~~ For clients not enrolled with a managed care organization, certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client’s need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the client’s level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

ITEM 99. Amend subrule 82.9(2) as follows:

82.9(2) Financial participation by resident. A resident’s payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state Medicaid payment is made. ~~The state Medicaid~~ will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

HUMAN SERVICES DEPARTMENT[441](cont'd)

ITEM 100. Rescind and reserve rule ~~441—82.11(249A)~~.

ITEM 101. Rescind and reserve rule ~~441—82.12(249A)~~.

ITEM 102. Amend subrule 82.15(1) as follows:

82.15(1) Claims. ~~Claims for service for clients not enrolled with a managed care organization must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims may~~ Such claims must be submitted electronically ~~on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039, Iowa Medicaid Long-Term Care Claim through~~ IME's electronic clearinghouse.

a. ~~When payment is made, the facility will receive a copy of Form 470-0039. The white copy of the original shall be returned as a claim for the next month. If the claim is submitted electronically, the facility will receive a remittance statement of the claims paid. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.~~

b. ~~When there has been a new admission, a discharge, a correction, or a claim for a reserved bed, the facility shall submit Form 470-0039 with the changes noted. Adjustments to electronically submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise.~~

ITEM 103. Amend rule 441—82.16(249A) as follows:

441—82.16(249A) Closing of facility. ~~When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the county office of the department resident's managed care organization or by the Iowa Medicaid enterprise for residents not enrolled with a managed care organization.~~

~~This rule is intended to implement Iowa Code section 249A.12.~~

ITEM 104. Amend subrule 82.17(2) as follows:

82.17(2) Auditing of proper billing and handling of patient funds.

a. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals or and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals or and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

c. to f. No change.

ITEM 105. Adopt the following **new** definitions of "Intermediate care facility for persons with an intellectual disability level of care," "Managed care organization," "Nursing facility level of care" and "Skilled nursing facility level of care" in rule ~~441—83.1(249A)~~:

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

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

HUMAN SERVICES DEPARTMENT[441](cont'd)

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 106. Amend paragraph **83.2(1)“d”** as follows:

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) No change.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care. The initial determination of the member’s level of care certification. The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) No change.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 107. Amend paragraph **83.3(3)“b”** as follows:

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations ~~and the client case plan~~ are completed.

ITEM 108. Amend subrule 83.3(4) as follows:

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations ~~and the case plan~~ are completed; but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) “*a*” and “*c*” do not apply is the date on which the income eligibility and level of care determinations ~~and the case plan~~ are completed.

HUMAN SERVICES DEPARTMENT[441](cont'd)

c. Eligibility for persons covered under subparagraph 83.2(1)“c”(3) shall exist on the date the income and resource eligibility and level of care determinations ~~and case plan~~ are completed, but shall not be earlier than the first of the month following the date of application.

d. No change.

ITEM 109. Amend rule 441—83.5(249A) as follows:

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 110. Amend rule 441—83.7(249A), introductory paragraph, as follows:

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with ~~rule 441—130.7(234) except that service~~ 441—paragraph 90.5(1)“b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

ITEM 111. Adopt the following **new** definitions of “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.21(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

HUMAN SERVICES DEPARTMENT[441](cont'd)

ITEM 112. Amend paragraph **83.22(1)“d”** as follows:

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) No change.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 113. Amend paragraph **83.23(4)“a”** as follows:

a. The effective date of eligibility ~~cannot precede the date the case manager signs the case plan is~~ the date on which the income eligibility and level of care determinations are completed.

ITEM 114. Amend rule 441—83.25(249A) as follows:

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 115. Adopt the following **new** definitions of “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.41(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

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- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- c. An individualized care plan that identifies support needs.
- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 116. Amend subparagraph **83.42(1)“b”(2)** as follows:

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

ITEM 117. Amend subrule 83.43(4) as follows:

83.43(4) Effective date of eligibility.

- a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations ~~and the service plan~~ are completed.
- b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations ~~and the service plan~~ are completed.
- c. No change.
- d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations ~~and the service plan~~ are completed; but shall not be earlier than the first of the month following the date of application.

ITEM 118. Amend rule 441—83.45(249A) as follows:

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 119. Adopt the following **new** definitions of “Intermediate care facility for persons with an intellectual disability level of care” and “Managed care organization” in rule **441—83.60(249A)**:

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

HUMAN SERVICES DEPARTMENT[441](cont'd)

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 120. Amend paragraph **83.61(1)“c”** as follows:

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

~~(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.~~

ITEM 121. Amend rule 441—83.64(249A) as follows:

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member’s functional status since the previous SIS or other full assessment.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 122. Adopt the following **new** definitions of “Intermediate care facility for persons with an intellectual disability level of care,” “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.81(249A)**:

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

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3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 123. Amend subrule 83.87(3) as follows:

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 124. Adopt the following **new** definitions of "Intermediate care facility for persons with an intellectual disability level of care," "Managed care organization," "Nursing facility level of care" and "Skilled nursing facility level of care" in rule **441—83.101(249A)**:

"Intermediate care facility for persons with an intellectual disability level of care" means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

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

"Nursing facility level of care" means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.
2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

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- c. An individualized care plan that identifies support needs.
- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 125. Amend paragraph **83.103(2)“e”** as follows:

e. The applicant, the applicant’s parent or guardian, or the applicant’s attorney in fact under a durable power of attorney for health care shall cooperate with the service worker or case manager in the development of the service plan, ~~which must be approved by the department service worker~~ prior to the start of services.

ITEM 126. Amend subrule 83.103(3) as follows:

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in ~~rule 441—83.102(249A)~~ subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in ~~rule 441—83.102(249A)~~ subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in ~~rule 441—83.102(249A)~~ subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

ITEM 127. Amend subrule 83.107(2) as follows:

83.107(2) Annual assessment. The IME medical services unit shall review the member’s need for continued care annually and recertify the member’s need for long-term care services, pursuant to paragraph 83.102(1) “h” and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

a. The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 128. Adopt the following **new** definitions of “Managed care organization” and “Psychiatric medical institution for children level of care” in rule **441—83.121(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the

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treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

ITEM 129. Amend subrule 83.122(3) as follows:

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

ITEM 130. Amend subrule 83.123(2) as follows:

83.123(2) Approval of waiver eligibility.

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) and (2) No change.

(3) The application is pending because the assessment ~~or the service plan~~ has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a ~~service plan~~ completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations ~~and the consumer's service plan~~ are completed.

ITEM 131. Amend subrule 83.123(3) as follows:

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; ~~and~~

b. Eligibility and level of care determinations have been made; ~~and~~

~~*c.* The service plan has been completed.~~

ITEM 132. Amend subrule 83.125(1) as follows:

83.125(1) Eligibility review.

a. Every 12 months, the ~~local office~~ department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

~~*a.* Continuing continuing~~ eligibility factors as specified in rule 441—83.122(249A).

b. ~~The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).~~ The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed department-approved assessment and supporting documentation as needed.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 133. Amend subrule 85.25(2) as follows:

85.25(2) Inpatient reimbursement for non-state-owned facilities effective July 1, 2014 January 1, 2016. Services rendered by non-state-owned facilities on or after July 1, 2014, ~~shall be reimbursed according to the Iowa Plan for Behavioral Health contractor's negotiated, provider-specific per diem rate~~ January 1, 2016, are paid on a fee-for-service basis.

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ITEM 134. Rescind and reserve subrule **90.3(3)**.

ITEM 135. Amend subparagraph **90.8(1)“a”(2)** as follows:

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 136. Rescind and reserve **441—Chapter 92**.

ARC 2241C**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 and 2015 Iowa Acts, Senate File 505, section 12(24), the Department of Human Services proposes to adopt a new Chapter 73, “Managed Care,” and to amend Chapter 88, “Managed Health Care Providers,” Iowa Administrative Code.

Iowa's Medicaid program is evolving to create a single system of care to address the health care needs of the whole person, including physical health, behavioral health, and long-term care services and supports. This initiative will deliver quality, patient-centered care to improve the overall health of the Medicaid population and will lead to a more predictable and sustainable budget.

Beginning January 1, 2016, HAWK-I members, Iowa Health and Wellness members, as well as the majority of Medicaid members will have their services coordinated through a managed care organization. Medicaid members who will not be served by a managed care organization include members of the Health Insurance Premium Payment (HIPP) Program, Medically Needy Program, or Programs for All-Inclusive Care for the Elderly (PACE); persons who are determined to be presumptively eligible for Medicaid services; and members who participate in the Medicare Savings Program; and members who are American Indian or Alaska Natives who do not volunteer to be served through a managed care organization in this program.

This Notice of Intended Action is one of two rule makings that the Department is proposing to implement the Governor's Medicaid Modernization Initiative as referenced in 2015 Iowa Acts, Senate File 505, section 12(24). The other rule making is published herein under Notice of Intended Action as **ARC 2242C**.

These amendments propose a new Chapter 73, “Managed Care,” to provide a single set of rules for managed care. Chapter 88 currently contains two divisions that pertain to managed care (Division I, “Health Maintenance Organization,” and Division IV, “Iowa Plan for Behavioral Health”) and are proposed to be rescinded. These amendments also rescind Division III, “Medicaid Patient Management,” which will no longer be appropriate. Chapter 88 will be retitled “Specialized Managed Care” and will include the current rules for other managed care options, including prepaid health plans (PHPs) and PACE.

The proposed rules in new Chapter 73 include:

- The requirements for the managed care organizations to participate in a contract with the Department.

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- The enrollment provisions.
- The disenrollment processes.
- Identification of covered services.
- Provisions regarding access to services and consumer choice of providers.
- The responsibilities for incident reporting, discharge planning, and annual reviews.
- The member appeal and grievance process requirements.
- The record management and documentation requirements.
- The process for making payments to a managed care organization.
- The claims payment requirements.
- The quality assurance and program integrity requirements.

The proposed amendments to Chapter 88:

- Rescind the rules in Division I, “Health Maintenance Organization”; Division III, “Medicaid Patient Management”; and Division IV, “Iowa Plan for Behavioral Health.”
- Renumber the rules in Division II, “Prepaid Health Plan,” and Division V, “Programs of All-Inclusive Care for the Elderly.”

Any interested person may make written comments on the proposed amendments on or before December 1, 2015. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, Fifth Floor, 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.

The Department of Human Services will hold public hearings in each of the Department’s service areas. The purpose of the public hearings is to receive oral or written comments on these proposed amendments regarding the implementation of the Governor’s Medicaid Modernization Initiative. At the hearings, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments.

Public hearings will be held at the following locations and times:

Cedar Rapids Service Area Cedar Rapids Public Library Whipple Auditorium 450 5th Avenue SE Cedar Rapids, Iowa	Wednesday, December 2, 2015 9 to 11 a.m.
Eastern Service Area Administration Building Boardroom 600 W. 4th Street Davenport, Iowa	Wednesday, December 2, 2015 1 to 3 p.m.
Des Moines Service Area Polk County River Place Conference Room 1-1A 2309 Euclid Avenue Des Moines, Iowa	Friday, December 4, 2015 9 to 11 a.m.
Northern Service Area Black Hawk County DHS, Pinecrest Office Building Conference Room 201 1407 Independence Avenue Waterloo, Iowa	Friday, December 4, 2015 1 to 3 p.m.
Western Service Area Council Bluffs Public Library 200 Pearl Street Council Bluffs, Iowa	Friday, December 4, 2015 2 to 4 p.m.

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).

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After analysis and review of this rule making, there will be a reduction in the staff of the current vendors providing administrative support to the current Medicaid program; however, the managed care organizations will be hiring new staff to accommodate their new line of business in Iowa.

These amendments are intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12.

The following amendments are proposed.

ITEM 1. Adopt the following new 441—Chapter 73 under Title VIII, “Medical Assistance”:

CHAPTER 73
MANAGED CARE

PREAMBLE

This chapter provides that most Iowa medical assistance program benefits will be provided through managed care. Notwithstanding any provisions of 441—Chapters 74 through 91, program benefits shall be provided through managed care as provided in this chapter. The program benefits provided through managed care will be paid for by managed care organizations participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care organization, consistent with this chapter and with the contract between the department and the managed care organization.

Implementation of managed care pursuant to this chapter is subject to approval by the Secretary of the United States Department of Health and Human Services (Secretary) of any Iowa state plan amendments and any waivers of the requirements of Title XIX of the Social Security Act that are required to allow for federal funding.

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements under Title XIX or the terms of the waiver shall prevail.

441—73.1(249A) Definitions.

“*Behavioral health services*” means mental health and substance use disorder treatment services.

“*Capitated payment*” means a monthly payment to the contractor on behalf of each enrollee for the provision of health services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

“*Choice counseling*” means the provision of unbiased information on managed care plans or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the managed care organizations or the state, to answer questions about each of the options available, and to facilitate enrollment with a managed care organization.

“*Claim*” means a formal request for payment for benefits received or services rendered.

“*Clean claim*” means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. “Clean claim” does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Code of Federal Regulations (CFR)*” means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

“*Community-based case management*” means a collaborative process of planning, facilitation, and advocacy for options and services to meet a member’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

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“*Contract*” means a contract between the department and a managed care organization. These contracts shall meet all applicable requirements of state and federal law, including the requirements of the Code of Federal Regulations, Title 42 CFR 434 as amended to October 16, 2015.

“*Covered services*” means physical health, behavioral health and long-term care services set forth in rule 441—73.5(249A).

“*Department*” means the Iowa department of human services.

“*Discharge planning*” means the process, which begins at admission, of determining an enrollee’s continued need for treatment services and of developing a plan to address ongoing needs.

“*Emergency medical condition*” means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

“*Emergency services*” means covered inpatient and outpatient services that are both furnished by a provider that is qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition.

“*EMTALA*” means the Emergency Medical Treatment and Active Labor Act.

“*Enrollee*” means a HAWK-I, Iowa Health and Wellness Plan or Medicaid member who is eligible for managed care organization enrollment and has been enrolled with a managed care organization as defined in subrule 73.3(2).

“*Enrollment broker*” means the entity the department uses to enroll persons in a managed care organization. The enrollment broker must be conflict free and meet all applicable requirements of state and federal law, including 42 CFR 438.10 as amended to October 16, 2015.

“*HAWK-I program*” means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

“*Health maintenance organization*” means a public or private organization which is licensed as a managed care organization or prepaid health plan under insurance division rules set forth in 191—Chapter 40.

“*HIPP*” means the health insurance premium payment program.

“*Home- and community-based services (HCBS)*” means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

“*Incident reporting*” means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention and/or result in hospitalization;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

“*Insolvency*” means a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business or when the liabilities of the entity exceed its assets.

“*Iowa Health and Wellness Plan*” means the medical assistance program set forth in 441—Chapter 74.

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“*Level of care*” means an evaluation to determine and establish an individual’s need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future (one month or less).

“*Long-term care (LTC)*” or “*long-term services and supports (LTSS)*” means the services of a nursing facility (NF), an intermediate care facility for persons with an intellectual disability (ICF/ID), state resource centers or services funded through Section 1915(c) home- and community-based services waivers, Section 1915(i) state plan home- and community-based habilitation program and the PACE program.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“*Mandatory enrollment*” means mandatory participation in a managed care organization as specified in subrule 73.3(2).

“*Medical loss ratio (MLR)*” means the percentage of capitation payments that is used to pay medical expenses.

“*Medically necessary services*” means those covered services that are, under the terms and conditions of the contract, determined through contractor utilization management to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
2. Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment;
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
4. Not primarily for the convenience of the member, the member’s physician or other provider; and
5. The most appropriate level of covered services that can safely be provided.

“*Medical records*” means all medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

“*Member*” means any person determined by the department to be eligible for the HAWK-I program, the Iowa Health and Wellness Plan, or the Medicaid program.

“*Money Follows the Person (MFP) Rebalancing Demonstration Grant*” means a federal grant that will assist Iowa in transitioning individuals from a nursing facility or ICF/ID into the community and in rebalancing long-term care expenditures.

“*Needs-based eligibility*” means an evaluation to determine and establish an individual’s need for habilitation services.

“*Network*” or “*provider network*” means a group of participating health care providers (both individual and group practitioners) linked through contractual arrangements to the contractor to supply a range of health care services.

“*Out-of-network provider*” means any provider that is not directly or indirectly employed by or does not have a provider agreement with the contractor or any of its subcontractors pursuant to the contract between the department and the contractor.

“*PACE*” means the program for all-inclusive care for the elderly.

“*Participating providers*” means the providers of covered physical health, behavioral health and long-term care services that have contracted with a managed care organization.

“*PMIC*” means a psychiatric medical institution for children.

“*Prior authorization*” means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

“*Warm transfer*” means a telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

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441—73.2(249A) Contracts with a managed care organization.

73.2(1) The department may enter into a contract with a managed care organization licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as defined in rule 441—73.6(249A).

73.2(2) The department shall determine that the managed care organization meets the following requirements:

a. The managed care organization shall make available the services it provides to enrollees as established in the contract.

b. The managed care organization shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the managed care organization's debts if the managed care organization becomes insolvent. The managed care organization shall comply with insurance division provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

c. The managed care organization shall attain and maintain accreditation by the National Committee on Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

73.2(3) If not already accredited, the managed care organization must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the managed care organization must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with insurance division rules set forth in 191—Chapter 40.

73.2(4) The contract shall meet the following minimum requirements. The contract shall:

- a.* Be in writing.
- b.* Specify the duration of the contract period.
- c.* List the services which must be covered.
- d.* Describe service access and provide access information.
- e.* List conditions for nonrenewal, termination, suspension, and modification.
- f.* Specify the method and rate of reimbursement.
- g.* Provide for disclosure of ownership and subcontracted relationships.
- h.* Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the managed care organization, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.
 - i.* Specify appeal and grievance rights.
 - j.* Specify all operational and service delivery expectations.
 - k.* Specify reporting requirements.
 - l.* Specify requirements for utilization management and quality improvement.
 - m.* Specify requirements for program integrity.
 - n.* Specify termination requirements and assessment of penalties.

441—73.3(249A) Enrollment.

73.3(1) *Enrollment area.* The coverage area for enrollment shall be statewide.

73.3(2) *Members subject to enrollment.* All HAWK-I program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

- a.* Members who are medically needy as defined at 441—subrule 75.1(35).
- b.* Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).
- c.* Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).
- d.* Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).

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e. Persons enrolled in the health insurance premium payment program (HIPP) pursuant to rule 441—75.21(249A).

f. Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).

g. American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

73.3(3) Enrollment process. The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to October 16, 2015.

a. General. Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

b. Tentative assignment. Members shall be tentatively assigned to a managed care organization and offered the opportunity to choose from the available managed care organizations within a time frame specified in the tentative assignment letter.

c. Request to change enrollment.

(1) A member shall have a minimum of ten days from the date of the tentative assignment letter to request enrollment with a different managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

(2) An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

d. Ongoing enrollment. Enrollees shall remain enrolled with the chosen managed care organization for a total of 12 months.

e. Enrollment cycle. Prior to the end of the enrollee's annual enrollment period, the enrollee shall be notified of the option to maintain enrollment with the current managed care organization or to enroll with a different managed care organization.

73.3(4) Effective date of enrollment. The effective date of enrollment shall be no later than the first day of the second month beginning after the date on which the managed care organization receives the designated managed health care choice form or written or verbal request.

73.3(5) Benefit reimbursement prior to enrollment.

a. Prior to the effective date of managed care enrollment, except as provided in paragraph 73.3(5) "b," the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

b. The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods, prior to the effective date of enrollment, in the following cases:

(1) Babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth; and

(2) Children enrolled in the HAWK-I program retroactive to the date of application. For purposes of this requirement, a retroactive Medicaid eligibility period is defined as a period of time up to three months prior to the Medicaid determination month.

441—73.4(249A) Disenrollment process.

73.4(1) Enrollee-requested disenrollment. An enrollee may request disenrollment with a managed care organization as follows:

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a. During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the managed care organization, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the managed care organization's grievance system. If the member does not experience resolution, the managed care organization shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The managed care organization does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment shall be determined by the department.

73.4(2) *Disenrollment by department.* Disenrollment will occur when:

a. The contract between the department and the managed care organization is terminated.

b. The enrollee becomes ineligible for Medicaid, the HAWK-I program or the Iowa Health and Wellness Plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the managed care organization will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care organization enrollment. See definition of "enrollee" in rule 441—73.1(249A).

d. The department has determined that participation in the HIPPP program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

e. Death of the enrollee.

f. The enrollee has changed residence to another state.

73.4(3) *Managed care organization-requested disenrollment.* A managed care organization shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health care needs or change in health care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs (except when the enrollee's continued enrollment seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the managed care organization shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees. The managed care organization shall have methods by which the department is assured that disenrollment is not requested for another reason.

73.4(4) *Disenrollment effective date.* The effective date of a department-approved disenrollment shall be no later than the first day of the second calendar month beginning after the month in which: (1) the enrollee requests disenrollment pursuant to subrule 73.4(1); (2) the department notifies the enrollee and managed care organization of disenrollment pursuant to subrule 73.4(2); or (3) the managed care organization requests disenrollment pursuant to subrule 73.4(3). The enrollee shall remain enrolled in the managed care organization and the managed care organization will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the managed care organization shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

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441—73.5(249A) Covered services.

73.5(1) Required services. A managed care organization shall provide:

a. For enrollees other than Iowa Health and Wellness Plan enrollees and HAWK-I program enrollees, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

- (1) Area education agency services.
- (2) Dental services not provided in an outpatient hospital setting.
- (3) Infant and toddler program services.
- (4) Local education agency services.
- (5) State of Iowa Veterans Home services.
- (6) Money Follows the Person grant-funded services.

b. Services as set forth in 441—Chapter 74 for Iowa Health and Wellness Plan enrollees.

c. Services as set forth in 441—Chapter 86 for HAWK-I program enrollees.

73.5(2) Community-based case management service. The managed care organization is required to provide services that meet requirements specified in the contract and in 441—subrule 90.5(1).

73.5(3) Health home services. The managed care organization is required to provide services that meet the requirements specified in 441—subrule 78.53(1) and as specified in the contract.

73.5(4) Value-added services. A managed care organization may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

441—73.6(249A) Amount, duration and scope of services.

73.6(1) The managed care organization shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the agency. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to October 16, 2015, the managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, the managed care organization shall require as a condition of payment managed care organization approval of admissions to a nursing facility, an intermediate care facility for persons with an intellectual disability, psychiatric medical institutions for children, and a mental health institute. Managed care organizations shall also require managed care organization approval of out-of-state placements as a condition of payment.

73.6(2) The managed care organization may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The managed care organization shall not:

a. Avoid costs for services covered in the contract by referring members to publicly supported health care resources.

b. Deny reimbursement of covered services based on the presence of a preexisting condition.

73.6(3) The managed care organization shall allow each enrollee to choose a health professional, to the extent possible and appropriate, within the managed care organization's provider network. The managed care organization shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.

441—73.7(249A) Emergency services.

73.7(1) Emergency services shall be available 24 hours a day, 7 days a week.

73.7(2) In accordance with federal funding requirements, including 42 CFR 438.114 as amended to October 16, 2015, the managed care organization shall:

a. Cover emergency services without the need for prior authorization and may not limit reimbursement to network providers.

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b. Cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the managed care organization.

c. Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

d. Cover the medical screening examination, as defined by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition.

73.7(3) The managed care organization shall not deny payment for:

a. Treatment obtained when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would result in placing the health of the enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

b. Treatment obtained when a representative of the managed care organization instructs the enrollee to seek emergency medical services.

441—73.8(249A) Access to service.

73.8(1) The managed care organization shall ensure enrollees have access to services as specified in the contract. In general, the managed care organization shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, 7-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

73.8(2) Choice of providers. An enrollee shall use the managed care organization's provider network unless the managed care organization has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to October 16, 2015, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the managed care organization's network.

73.8(3) Continuity of care. The managed care organization shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

73.8(4) Adequate service referral support and after-hours call-in coverage. The managed care organization shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

a. Member helpline. The managed care organization shall maintain a dedicated toll-free member services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal managed care organization departments, such as to care coordinators.

b. Nurse call line. The managed care organization shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, 7 days a week from trained medical professionals.

441—73.9(249A) Incident reporting. The managed care organization shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS Waivers, the Section 1915(i) Habilitation Program, and as required for licensure of programs through the department of inspections

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and appeals. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

441—73.10(249A) Discharge planning. The managed care organization shall establish policies and procedures, subject to approval by the department, that protect an individual from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The managed care organization shall facilitate a seamless transition whenever a member transitions between facilities or residences.

441—73.11(249A) Level of care assessment and annual reviews. The managed care organization shall establish policies and procedures to ensure the implementation of level of care and needs-based eligibility assessments and reassessments as required in the contract and consistent with the department's level of care and needs-based eligibility assessment process and the requirements provided in 441—Chapters 75, 78, 81, 82, 83, and 85. Waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan.

73.11(1) Initial level of care assessment. Managed care organizations are responsible for conducting level of care and needs-based eligibility assessments for a current enrollee who requires a level of care or a needs-based eligibility assessment. The managed care organization shall perform the assessment using department-approved assessment tools. The results of the assessment shall be submitted to the IME medical services unit for determination of level of care or needs-based eligibility.

73.11(2) Annual continued stay reviews, continued care reviews and redeterminations. When an enrollee requires a continued stay review, a continued care review or a redetermination, the managed care organization shall use department-approved assessment tools. If the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect the enrollee's level of care or needs-based eligibility, the managed care organization shall submit the assessment findings to the IME medical services unit for determination of level of care or needs-based eligibility.

73.11(3) At any time, if the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect level of care or needs-based eligibility, the managed care organization shall conduct a level of care or needs-based assessment using the department-approved tools and submit the assessment to the IME medical services unit for determination of level of care or needs-based eligibility.

441—73.12(249A) Appeal of managed care organization actions. The managed care organization shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal a managed care organization action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438.400(b) as amended to October 16, 2015.

73.12(1) *Managed care organization appealable actions.* Managed care organization actions that may be appealed include:

- a. Denial or limited authorization of a requested service, including the type or level of service.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment of service.
- d. Failure to provide services in a timely manner as defined by the department.
- e. Failure of the managed care organization to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended to October 16, 2015.
- f. For a resident of a rural area that has only one contractor, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the network (if applicable).

73.12(2) *Appeal process.* The managed care organization appeal process shall be approved by the department and shall:

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- a. Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.
- b. Require acknowledgment of the receipt of a request for an appeal within three working days.
- c. Allow for participation by the enrollee and the provider.
- d. Provide for resolution of nonexpedited appeals to be concluded within 45 calendar days of receipt of the request unless an extension is requested.
- e. Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within three business days of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.
- f. Ensure that the review will be made by qualified professionals who were not involved with the original action.
- g. Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

441—73.13(249A) Appeal to department. If the enrollee is not satisfied with the final decision rendered by the managed care organization through the managed care organization's appeal process, the enrollee may appeal an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7.

441—73.14(249A) Continuation of benefits. The managed care organization shall be required to continue the member's benefits during the appeal in accordance with federal funding requirements, including 42 CFR 438.420 as amended to October 16, 2015.

73.14(1) If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

- a. The enrollee withdraws the appeal request;
- b. Ten days have passed from the date the managed care organization mailed the notice of an adverse decision, unless a state fair hearing has resolved the matter; or
- c. The time period or service limits of a previously authorized service have been met.

73.14(2) If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the managed care organization's action, the managed care organization may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that services were furnished solely because of the requirements to maintain benefits during the appeal.

73.14(3) If the managed care organization or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the managed care organization or the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the managed care organization must pay for these services.

441—73.15(249A) Grievances. The managed care organization shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.

441—73.16(249A) Written record. All enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances.

441—73.17(249A) Information concerning procedures relating to the review of managed care organization decisions and actions. The managed care organization's written procedures for the

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review of managed care organization decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

441—73.18(249A) Records and reports.

73.18(1) *Records system.* The managed care organization shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including rule 441—79.3(249A) and 42 CFR 456 as amended to October 16, 2015, throughout the course of the contract. The record system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of decisions made by the managed care organization, based upon medical necessity.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the managed care organization including follow up of the implementation of discharge plans and referral to other providers.

73.18(2) *Content of individual treatment record.* The managed care organization shall assure participating providers maintain an adequate record-keeping system which includes a complete medical or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of rule 441—79.3(249A) and pursuant to federal funding requirements, including 42 CFR 456 as amended to October 16, 2015.

73.18(3) *Confidentiality of health care, mental health care, and substance abuse information.* The managed care organization shall protect and maintain the confidentiality of health care, mental health care, and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

441—73.19(249A) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the managed care organization. The department or HHS may audit and inspect any records of a managed care organization, or the subcontractor of the managed care organization, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—73.20(249A) Marketing. Managed care organization marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the managed care organizations and contract terms. The department shall approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104 as amended to October 16, 2015.

441—73.21(249A) Enrollee education.

73.21(1) *Use of services.* The managed care organization shall provide written information to all enrollees on the use of services the managed care organization is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of managed care organization decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

73.21(2) *Outreach to members with special needs.* The managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with

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psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual or hearing impairments.

73.21(3) Patient rights and responsibilities. The managed care organization shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

441—73.22(249A) Payment to the managed care organization.

73.22(1) Capitation rate. In consideration for all services rendered by a managed care organization under a contract with the department, the managed care organization will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms defined in the managed care contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act, the health insurance providers fee. This capitation rate, inclusive of the amounts withheld and the health insurance providers fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the managed care organization meets metrics defined in the managed care contract.

73.22(2) Determination of rate. The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6 as amended to October 16, 2015, Actuarial Standards of Practice 49, and other related CMS regulations and generally accepted actuarial principles and practices.

73.22(3) Third-party liability. If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses, it is the right and responsibility of the managed care organization to investigate these third-party resources and attempt to obtain payment. The managed care organization shall retain all funds collected from third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

73.22(4) Medical loss ratio. The managed care organization shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the managed care organization.

441—73.23(249A) Claims payment by the managed care organization.

73.23(1) The managed care organizations shall pay or deny:

- a. Ninety percent of all clean claims within 14 calendar days of receipt,
- b. Ninety-nine point five percent of all clean claims within 21 calendar days of receipt, and
- c. One hundred percent of all claims within 90 calendar days of receipt.

73.23(2) Limits on payment responsibility for services.

a. The managed care organization is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

b. The managed care organization has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

c. Payment responsibilities for emergency room services are as provided at rule 441—73.7(249A).

73.23(3) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers.

441—73.24(249A) Quality assurance. The managed care organization shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

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441—73.25(249A) Certifications and program integrity. The managed care organization shall develop and implement policies, procedures and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The managed care organization shall cooperate and collaborate with the department on all program integrity activities. The managed care organization shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to October 16, 2015.

These rules are intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12.

ITEM 2. Amend **441—Chapter 88**, title, as follows:

SPECIALIZED MANAGED HEALTH CARE PROVIDERS PROGRAMS

ITEM 3. Rescind **441—Chapter 88**, Preamble, and adopt the following new preamble in lieu thereof:

PREAMBLE

This chapter provides for specialized programs of managed care, within the Iowa medical assistance program but outside of managed care pursuant to 441—Chapter 73. Managed care providers under these programs are not required to comply with 441—Chapter 73.

ITEM 4. Rescind **441—Chapter 88, Division I** title and rules **441—88.1(249A)** to **441—88.14(249A)**.

ITEM 5. Amend **441—Chapter 88, Division II** title, as follows:

DIVISION II
PREPAID HEALTH PLANS

ITEM 6. Renumber rules **441—88.21(249A)** to **441—88.33(249A)** as **441—88.1(249A)** to **441—88.13(249A)** and update cross references accordingly.

ITEM 7. Rescind **441—Chapter 88, Division III** title and rules **441—88.41(249A)** to **441—88.52(249A)**.

ITEM 8. Rescind **441—Chapter 88, Division IV** title and rules **441—88.61(249A)** to **441—88.75(249A)**.

ITEM 9. Amend **441—Chapter 88, Division V** title, as follows:

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

ITEM 10. Renumber rules **441—88.81(249A)** to **441—88.88(249A)** as **441—88.21(249A)** to **441—88.28(249A)** and update cross references accordingly.

ARC 2243C

HUMAN SERVICES DEPARTMENT[441]

Notice of Termination

Pursuant to the authority of Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, the Department of Human Services terminates the rule making initiated by its Notice of Intended Action published in the Iowa Administrative Bulletin on August 5, 2015, as **ARC 2097C** proposing to amend Chapter 79, “Other Policies Relating to Providers of Medical and Remedial Care,” and Chapter 83, “Medicaid Waiver Services,” Iowa Administrative Code.

The Notice of Intended Action proposed to implement a cost-savings initiative that was part of the basis for the Department’s budgets for state fiscal years 2016 and 2017, as appropriated by the 2015 Iowa legislature. As appropriated, the Department’s budgets assumed savings from this initiative beginning

HUMAN SERVICES DEPARTMENT[441](cont'd)

July 1, 2015. The amendments would have capped the monthly cost of all intellectual disability (ID) waiver services provided to a member (other than home and vehicle modifications) at the maximum monthly cost of services in an intermediate care facility for persons with intellectual disabilities (ICF/ID).

The Department provided for additional comment at public hearings that were added under Amended Notice of Intended Action **ARC 2153C** published in the Iowa Administrative Bulletin on September 30, 2015.

The Department is terminating **ARC 2097C**, a cost containment rule making, due to the implementation of managed care and decreased cost savings initially associated with this proposal.

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

ARC 2239C**REVENUE DEPARTMENT[701]****Amended Notice of Intended Action**

Pursuant to the authority of Iowa Code sections 17A.3 and 423.42, the Department of Revenue hereby gives notice that a public hearing will be held on December 1, 2015, at 2 p.m. in the Auditorium in the Wallace State Office Building, 502 East Ninth Street, Des Moines, Iowa. The public hearing is being held pursuant to a request by the Administrative Rules Review Committee.

The purpose of the public hearing is to receive oral or written comments on proposed amendments to Chapter 15, "Determination of a Sale and Sale Price," Chapter 18, "Taxable and Exempt Sales Determined by Method of Transaction or Usage," Chapter 219, "Sales and Use Tax on Construction Activities," and Chapter 230, "Exemptions Primarily Benefiting Manufacturers and Other Persons Engaged in Processing," Iowa Administrative Code. The proposed amendments were published under Notice of Intended Action in the Iowa Administrative Bulletin on September 30, 2015, as **ARC 2178C**.

The primary purpose of this rule making is to amend rules that are related to the definition of machinery and equipment for purposes of the manufacturing exemption found in Iowa Code section 423.3(47). This exemption and its related rules have been the subject of substantial confusion and controversy. Most recently, the Department has received a petition for rule making with regard to the exemption. Under the Department's current rules, many items that might ordinarily be thought of as machinery and equipment are considered real property and are therefore taxed as building materials, making the items ineligible for the manufacturer's machinery and equipment exemption under the rules established pursuant to Iowa Code section 423.3(47). The proposed amendments implement a policy that eliminates, to the extent permitted by Iowa Code section 423.3(47), administratively burdensome distinctions that do not reflect modern manufacturing in Iowa. In this Amended Notice of Intended Action, the applicability date of the proposed amendments is changed from January 1, 2016, to July 1, 2016, as requested by the Administrative Rules Review Committee. The proposed amendments in this Amended Notice of Intended Action are otherwise identical to the proposed amendments published under Notice of Intended Action as **ARC 2178C**.

Items 1, 2, 3, and 7 amend existing rules on exemptions by adding cross references to new rules 701—230.14(423) to 701—230.22(423). The items also update terminology in the existing rules and make nonsubstantive stylistic changes.

Item 4 amends rule 701—219.11(423) to notify contractors that computers, machinery, and equipment used in an exempt manner under Iowa Code section 423.3(47) may remain tangible personal property after installation. The amendment also updates cross references, terminology, and the list of items that normally become part of realty after installation.

Item 5 amends rule 701—219.12(423) to inform contractors that the Department of Revenue will consider whether property is used for an exempt purpose under Iowa Code section 423.3(47) in deciding whether the property remains tangible personal property after installation. The amendment also removes an obsolete example and references to outdated court cases.

Item 6 amends subrule 219.13(3) by dividing the subrule into lettered paragraphs and updating an example.

REVENUE DEPARTMENT[701](cont'd)

Item 8 creates new rule 701—230.14(423). The rule provides a directory and definitions for all exemptions under Iowa Code section 423.3(47). The definition of “computer” is a consolidation of definitions from other related rules. The definition of “equipment” closely mirrors the statute in the context of the current Iowa manufacturing environment. The definition of “replacement parts” omits the presumption that exempt replacement parts have a useful life of 12 months or more. The rule expands the guidance for materials used to construct or self-construct computers, machinery, and equipment.

Item 9 creates new rule 701—230.15(423), which explains the exemption for property directly and primarily used in processing by a manufacturer.

Item 10 creates new rule 701—230.16(423), which applies to the exemption for property directly and primarily used by a manufacturer to maintain integrity or unique environmental conditions.

Item 11 creates new rule 701—230.17(423), which addresses the exemption for property directly and primarily used in research and development of new products or processes of processing.

Item 12 creates new rule 701—230.18(423), which pertains to the exemption for computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise.

Item 13 creates new rule 701—230.19(423), which discusses the exemption for property directly and primarily used in recycling or reprocessing of waste products.

Item 14 creates new rule 701—230.20(423), which describes the exemption for pollution-control equipment used by a manufacturer.

Item 15 creates new rule 701—230.21(423), which relates to the exemption for fuel used in exempt property.

Item 16 creates new rule 701—230.22(423), which provides guidance for the exemption for the design and installation of new industrial machinery and equipment.

After analysis and review of this rule making, the Department finds that the changes to the program are likely to have a positive impact on jobs. The proposed changes will expand the number of items that qualify as exempt computers, machinery, or equipment. The Department estimates that, between 2017 and 2021, manufacturers will reduce their sales and use tax burden by \$35 million to \$40 million annually under the proposed amendments. The Department also estimates that manufacturers will reduce their local option sales tax burden by \$5 million to \$6 million annually between 2017 and 2021. Reducing the tax burden on business inputs for manufacturers is likely to have a positive impact on jobs.

These amendments are intended to implement Iowa Code sections 423.2(1)“b” and “c,” 423.3(47), and 423.3(48).

The following amendments are proposed.

ITEM 1. Amend paragraph **15.3(3)“a,”** definition of “Fuel consumed in processing,” as follows:

“*Fuel consumed in processing*” includes fuel used in grain drying; or providing heat or cooling for livestock buildings, fuel used for generating electric current, fuel consumed in implements of husbandry engaged in agricultural production, as well as fuel used in “processing” as defined in rules 701—18.29(422,423), and 701—18.58(422,423), and 701—230.15(423). See rule 701—17.2(422) for a detailed description of “fuel used in processing.” See rule 701—17.3(422,423) for extensive discussion regarding electricity and steam used in processing.

ITEM 2. Amend subrule 18.29(7) as follows:

18.29(7) *Other department rules concerned with processing.* Various sections of the Iowa Code set out activities ~~which~~ that are defined by statute to be “processing.” The rules interpreting these statutes for the purposes of sales and use tax law are the following:

a. ~~701—15.3(422,423) Certificates of resale, processing, and fuel used in processing Exemption certificates, direct pay permits, fuel used in processing, and beer and wine wholesalers.~~

b. 701—17.2(422) Fuel used in processing—when exempt.

c. ~~701—17.3(422,423) Electricity, steam, or other taxable services to be used in the processing of tangible personal property intended to be sold ultimately at retail are exempt from sales tax Processing exemptions.~~

REVENUE DEPARTMENT[701](cont'd)

- d.* 701—17.9(422,423) Sales of breeding livestock, fowl, and certain other property used in agricultural production. See 701—subrules 17.9(4), 17.9(5), 17.9(6), and 17.9(7) for processing exemptions.
- e.* 701—17.14(422,423) Chemicals, solvents, sorbents, or reagents used in processing.
- f.* 701—18.3(422,423) Chemical compounds used to treat water.
- g.* 701—18.45(422,423) Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997.
- h.* 701—18.58(422,423) Sales or rentals of machinery, equipment, and computers and sales of fuel and electricity to manufacturers and sales or rentals of computers to commercial enterprises for periods on and after July 1, 1997, but before July 1, 2016.
- i.* 701—26.2(422) Enumerated services exempt. See 701—subrule 26.2(2) for the processing exemption.
- j.* 701—28.2(423) Processing of property defined.
- k.* 701—33.3(423) Fuel consumed in creating power, heat, or steam for processing or generating electric current.
- l.* 701—33.7(423) Property used to manufacture certain vehicles to be leased.
- m.* For property sold as part of a contract entered into on or after July 1, 2016, computers, machinery, and equipment used for an exempt purpose under Iowa Code section 423.3(47). See rules 701—230.14(423) to 701—230.22(423).

ITEM 3. Amend rule 701—18.58(422,423), introductory paragraph, as follows:

701—18.58(422,423) Exempt sales or rentals of computers, industrial machinery and equipment, and exempt sales of fuel and electricity on and after July 1, 1997, but before July 1, 2016. The sale or rental of machinery, equipment, or computers used by a manufacturer in processing; the sale or rental of a computer used in the processing or storage of data or information by an insurance company, financial institution, or commercial enterprise; and the sale or rental of various other types of tangible personal property are, under certain circumstances, exempt from tax as of July 1, 1997, but before July 1, 2016. For sales that occur as part of a contract entered into on or after July 1, 2016, see rules 701—230.14(423) to 701—230.22(423).

ITEM 4. Amend rule 701—219.11(423) as follows:

701—219.11(423) Distinguishing machinery and equipment from real property. A construction contract may include many activities, but it does not include a contract for the sale and installation of machinery or equipment. Machinery and equipment includes property that is tangible personal property when it is purchased and remains tangible personal property after installation. Generally, tangible personal property can be moved without causing damage or injury to itself or to the structure, it does not bear the weight of the structure, and it does not in any other manner constitute an integral part of a structure. ~~Manufactured machinery and equipment which does not become permanently annexed to the realty remains tangible personal property after installation.~~ For exemptions related to the sale of computers, machinery, and equipment if the sale occurs as part of a contract entered into on or after July 1, 2016, see rules 701—230.14(423) to 701—230.22(423).

219.11(1) The following is a list of property ~~which~~ that, under normal conditions, remains tangible personal property after installation. The list is nonexclusive and is offered for illustrative purposes only:

- a.* Furniture, radio and television sets and antennas, washers and dryers, portable lamps, home freezers, portable appliances and window air-conditioning units.
- b.* Portable items such as casework, tables, counters, cabinets, lockers, athletic and gymnasium equipment, and other related easily movable property attached to the structure.
- c.* Machinery, equipment, tools, appliances, and materials used exclusively as such by manufacturers, industrial processors and others performing a processing function with the items, including:

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(1) Computers, machinery, and equipment directly and primarily used in processing by a manufacturer (see rule 701—230.15(423)).

(2) Computers, machinery, and equipment directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, machinery, and equipment used in processing by a manufacturer (see rule 701—230.16(423)).

(3) Computers, machinery, and equipment directly and primarily used in research and development of new products or processes of processing (see rule 701—230.17(423)).

(4) Computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise (see rule 701—230.18(423)).

(5) Computers, machinery, and equipment directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).

(6) Pollution-control equipment used by a manufacturer, including but not limited to that required or certified by an agency of Iowa or the United States government (see rule 701—230.20(423)).

d. Office, bank, and savings and loan association furniture and equipment, including office machines.

e. Radio, television, and cable television station equipment, but not broadcasting towers.

f. Certain equipment used by restaurants and in institutional kitchens; for instance, dishwashers, stainless steel wall cabinets, stainless steel natural gas stoves, stainless steel natural gas convection ovens, and combination ovens and steamers with stands. This paragraph is not applicable to similar items used in residential kitchens. See Petition of Taylor Industries Inc. (Dkt No. 94-30-6-0367, 3-14-95).

219.11(2) The following is a list of property ~~which~~ that, under normal conditions, becomes a part of realty. The list is nonexclusive and is offered for illustrative purposes only:

a. Boilers and furnaces.

b. Built-in household items such as kitchen cabinets, dishwashers, sinks (including faucets), fans, garbage disposals, and incinerators.

c. Buildings, and structural and other improvements to buildings, including awnings, canopies, foundations for machinery, floors (including computer room floors), walls, general wiring and lighting facilities, roofs, stairways, stair lifts, sprinkler systems, storm doors and windows, door controls, air curtains, loading platforms, central air-conditioning units, building elevators, sanitation and plumbing systems, decks, and heating, cooling and ventilation systems.

d. Fixed (year-round) wharves and docks.

e. Improvements to land including patios, retaining walls, roads, walks, bridges, fencing, railway switch tracks, ponds, dams, ditches, wells, underground irrigation systems, drainage, storm and sanitary sewers, and water supply lines for drinking water, sanitary purposes, and fire protection. ~~Reference rule 701—18.35(422,423)~~ See rule 701—226.10(423) relating to drainage tile.

f. Mobile and modular homes installed on foundations.

g. Planted nursery stock.

h. Residential water heaters, water softeners, intercoms, garage door opening equipment, pneumatic tube systems, and music and sound equipment (except portable equipment).

i. Safe deposit boxes, drive-up and walk-up windows, night depository equipment, remote TV auto teller systems, vault doors, and camera security equipment (except portable equipment).

j. Seating in auditoriums and theaters and theater stage lights (except portable seating and lighting).

~~*k.* Silos and grain storage bins.~~

~~*l.* Storage tanks constructed on the site.~~

~~*m.* *k.* Swimming pools (wholly or partially underground (except portable pools)).~~

~~*n.* *l.* Truck platform scale foundations.~~

~~*o.* *m.* Walk-in cold storage units that become a component part of a building.~~

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ITEM 5. Amend rule 701—219.12(423) as follows:

701—219.12(423) Tangible personal property which that becomes structures. Items ~~which that~~ are manufactured as tangible personal property can, by their nature, become structures. However, the determination is factual and must be made on an item-by-item basis. For exemptions related to the sale of computers, machinery, and equipment occurring as part of a contract entered into on or after July 1, 2016, see rules 701—230.14(423) to 701—230.22(423). The following is a listing of criteria ~~which that~~ courts have used in making such a determination:

1. The degree of architectural and engineering skills necessary to design and construct the structure.
2. The overall scope of the business and the contractual obligations of the person designing and building the structure.
3. The amount and variety of materials needed to complete the structure, including the identity of materials prior to assembly and the complexity of assembly.
4. The size and weight of the structure.
5. The permanency or degree of annexation of the structure to other real property which would affect its mobility.
6. The cost of building, moving or dismantling the structure.
7. For property sold as part of a contract entered into on or after July 1, 2016, computers, machinery, or equipment used for an exempt purpose under Iowa Code section 423.3(47) remains tangible personal property. See rules 701—230.14(423) to 701—230.22(423).

~~EXAMPLE. A farm silo, which is a prefabricated glass lined structure, is intended to be permanently installed. The prefabricated glass lined structure is 70 feet high and 20 feet around, weighs 30 tons, and is affixed to a concrete foundation weighing 60 tons which is set in the ground specifically for the purpose of supporting the silo. The assembly kit includes 105 steel sheets and 7000 bolts. The silo can be removed without material injury to the realty or to the unit itself at a cost of \$7,000. In view of its massive size, the firm and permanent manner in which it is erected on a most substantial foundation, its purpose and function, the expense and size of the task and the difficulty of removing it, the silo is considered a structure and not machinery or equipment. *Wisconsin Department of Revenue v. A. O. Smith Harvestore*, 240 N.W.2d 357 (Wisc. 1976).~~

~~The above criteria are intended only to be a summation of factors which the department will consider in determining whether or not a project involves construction. The following cases are used as reference material: *Wisconsin Department of Revenue v. A. O. Smith Harvestore Products, Inc.*, 240 N.W.2d 357 (Wisc. 1976); *Prairie Tank or Construction Co. v. Department of Revenue*, 364 N.W.2d 963 (Ill. 1977); *Levine v. State Board of Equalization*, 299 P. 2d 738 (Calif. 1956); *State of Alabama v. Air Conditioning Engineers, Inc.*, 174 So 2d 315 (Ala. 1965); *A. S. Schulman Electric Company v. State Board of Equalization*, 122 Cal. Rptr 278 (Calif. 1975); *Western Pipeline Constructors, Inc. v. J. M. Dickinson*, 310 S.W.2d 455 (Tenn.); and *City of Pella Municipal Light Plant*, Order of the Director of Revenue, June 16, 1975.~~

ITEM 6. Amend subrule 219.13(3) as follows:

219.13(3) “On or connected with.” The term “on or connected with” is broad and should be used to convey generally accepted meaning. Therefore, in a specific situation, the facts relating thereto are controlling in determining whether the exemption is applicable. “On or connected with” does not connote that those things connected have to be primary or subsidiary to the construction, reconstruction, alteration, expansion or remodeling of the real property.

a. Incidental relationship. An incidental relationship can qualify the activity for exemption if the relationship forms an intimate connection with the construction activity. For example, the service of excavating and grading relating to the clearing of land to begin construction of a building would qualify for the exemption; however, excavating and grading land without motive toward construction would not qualify for exemption even though at some later date plans to construct a building were created and a structure was actually erected.

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b. Proximity in time. The presence of a time relationship can also be a factor in determining the applicability of exemption. For example, tax would not apply to separate labor charges relating to the installation of ~~production machinery and~~ institutional kitchen equipment in a building while remodeling of the real property was in progress. (Tax could apply to the sales price of the ~~production machinery and equipment~~; ~~reference rule 701—18.58(422,423)~~ institutional kitchen equipment; see rule 701—230.14(423)). However, if a year after all construction activity has ended, the owner decides to install a piece of ~~production machinery~~ institutional kitchen equipment in the building, any taxable enumerated services relating thereto would be subject to tax. Further, if, following construction, the land is graded for the purpose of seeding a new lawn, the exemption would be applicable. However, if the lawn does not grow and the land is regraded the following year, the exemption would not be applicable. ~~Reference 701—subrule 18.58(8) for the exemption regarding the installation of new industrial machinery and equipment.~~ Therefore, the motive behind the activity and the course of events that could reasonably be expected to occur would be a further consideration in determining if the exemption is applicable.

c. Physical proximity. A physical relationship is also a factor that should be evaluated. If a building is constructed to house machinery, any enumerated services relating to the installation of that machinery would be exempt from tax. For example, piping joining two pieces of equipment housed in separate buildings would qualify for exemption if the equipment in either building was installed while such new construction, reconstruction, alteration, expansion or remodeling to the structure was also taking place to house the equipment.

d. Totality of the facts and circumstances. ~~On the other hand, an~~ An incidental relationship, a time relationship, and close physical proximity may not be enough to support the conclusion that a taxable service is performed in connection with new construction or reconstruction. For example, a homeowner hires a general contractor to add a new room to an existing home (which is new construction; see 219.13(2) “d”). The existing home is in need of a number of the repairs described in subrule 219.13(1); for example, it is in need of rewiring and replacement of a broken window. The general contractor rewires the home and repairs the window in addition to building the new room. The taxable services which the general contractor performs while rewiring the home and repairing the window are not performed in connection with the construction of the new room simply because those services happen to be performed at the same time and on the same home as the new construction. If the addition of the new room were the cause of the need for the taxable service (e.g., the window was broken during construction of the new room) and not just a convenient occasion for performance of the service, that performance would be exempt from tax. ~~The department would like to emphasize that~~ facts and motives are important in the determination of the taxability of services relating to construction activities. However, it should also be noted that taxes on enumerated services are applicable to repair or installation work that is not a construction activity. ~~Refer to~~ See subrule 219.13(1) relating to persons who make repairs or perform enumerated services for more information.

ITEM 7. Amend rule 701—230.5(423) as follows:

701—230.5(423) Exempt sales of gases used in the manufacturing process. Sales of argon and other similar gases to be used in the manufacturing process are exempt from tax. For the purposes of this rule, only inert gases are gases ~~which that~~ which that are similar to argon. An “inert gas” is any gas ~~which that~~ which that is normally chemically inactive. It will not support combustion and cannot be used as either a fuel or as an oxidizer. Argon, helium, neon, krypton, radon, and xenon are inert gases. Oxygen, hydrogen, and methane are nonexclusive examples of gases ~~which that~~ which that are not inert. These sales are exempt only if the gas is purchased by a “manufacturer,” for use in “processing,” as those terms are defined in ~~referenced~~ 701—subrule 18.58(1) subrules 230.15(3) and 230.15(4).

This rule is intended to implement Iowa Code section 423.3(51).

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ITEM 8. Adopt the following new rule 701—230.14(423):

701—230.14(423) Exemption for the sale of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment used for certain manufacturing purposes if the sale occurs as part of a contract entered into on or after July 1, 2016. Rules 701—230.14(423) to 701—230.20(423) exempt the sales price of computers, machinery, and equipment used in an exempt manufacturing purpose. Rule 701—230.21(423) exempts the purchase of fuel used in such machinery and equipment. Rule 701—230.22(423) exempts the service of designing or installing such machinery and equipment. Rules 701—230.14(423) to 701—230.22(423) apply to sales of such products occurring as part of a contract entered into on or after July 1, 2016. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423). A sale occurs as part of a contract entered into prior to July 1, 2016, if the purchaser enters into a contract with a retailer to purchase the product and the contract date is prior to July 1, 2016, or if the purchaser enters into a contract with a contractor, subcontractor, or builder to construct or assemble the property and the contract date is prior to July 1, 2016.

230.14(1) Generally. The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax if the property is any of the following:

- a. Directly and primarily used in processing by a manufacturer (see rule 701—230.15(423)).
- b. Directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, machinery, and equipment used in processing by a manufacturer, including test equipment used to control quality and specifications of the product (see rule 701—230.16(423)).
- c. Directly and primarily used in research and development of new products or processes of processing (see rule 701—230.17(423)).
- d. Computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise (see rule 701—230.18(423)).
- e. Directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).
- f. Pollution-control equipment used by a manufacturer, including but not limited to that required or certified by an agency of this state or of the United States government (see rule 701—230.20(423)).
- g. Fuel used in creating heat, power, steam, or for generating electrical current, or from the sale of electricity, consumed by computers, machinery, or equipment used in an exempt manner described in paragraph “a,” “b,” “c,” “e,” or “f” (see rule 701—230.21(423)).

230.14(2) Computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment.

a. *Computers.* A “computer” is an electronic device that accepts information in digital or similar form and manipulates the information for a result based on a sequence of instructions. A computer includes all devices fastened to it by means of signal cables or any communication medium that serves the function of a signal cable. Nonexclusive examples of devices fastened by a signal cable or other communication medium are terminals, printers, display units, card readers, tape readers, document sorters, optical readers, and card or tape punchers. A computer also includes any operating system or executive program, but not application software, purchased as part of the sale of the computer for which the operating system or executive program operates. For purposes of this paragraph, “operating system or executive program” means computer software that is fundamental and necessary to the functioning of a computer. The operating system or executive program controls the operation of a computer by managing the allocation of all system resources, including the central processing unit, main and secondary storage, input/output devices, and the processing of programs. This is in contrast to application software, which is a collection of one or more programs used to develop and implement the specific applications that the computer is to perform and which calls upon the services of the operating system or executive program. Application software, or an operating system or executive program

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priced separately or sold at a later time from the computer for which the operating system or executive program operates, may be taxable as “prewritten computer software.” See rule 701—211.1(423).

b. Machinery. “Machinery” is any mechanical, electrical, or electronic device designed and used to perform some function and to produce a certain effect or result. Machinery also includes all devices used or required to control, regulate, or operate a piece of machinery, provided such devices are directly connected with or are an integral part of the machinery and are used primarily for control, regulation, or operation of machinery. Jigs, dies, tools, and other devices necessary to the operation of or used in conjunction with the operation of what would be ordinarily thought of as machinery are also considered to be machinery. All property that is in the nature of machinery (other than structural components of a building or other inherently permanent structure) is considered tangible personal property even if located outside of a building. A structure that is essentially machinery remains tangible personal property for purposes of this paragraph. For more information on distinguishing machinery from buildings and other constructed realty, see subparagraph 230.14(2) “f”(1).

c. Equipment. In general usage, “equipment” refers to devices or tools used to produce a final product or achieve a given result. Equipment includes supplies that do not qualify as “replacement parts,” such as drill bits, grinding wheels, punches, taps, reamers, saw blades, lubricants, coolants, sanding discs, sanding belts, and air filters. All property that is in the nature of equipment (other than structural components of a building or other inherently permanent structure) is considered tangible personal property even if located outside of a building. A structure that is essentially equipment may remain tangible personal property for purposes of this paragraph. For more information on distinguishing equipment from buildings and other constructed realty, see subparagraph 230.14(2) “f”(1).

d. Replacement parts. “Replacement part” means tangible personal property other than computers, machinery, or equipment, regardless of the cost or useful life of such tangible personal property. A replacement part can be separated from the computer, machinery, or equipment. A “replacement part” is a part or component of a computer, machinery, or equipment that came with the original item purchased or has been added over time to improve or restore the computer, machinery, or equipment.

e. Materials used to construct or self-construct computers, machinery, and equipment. “Materials used to construct or self-construct computers, machinery, and equipment” means tangible personal property that is incorporated into a computer, machinery, or equipment when the computer, machinery, or equipment is constructed or assembled. Materials used to construct a structure that is essentially machinery or equipment are exempt from sales and use tax so long as the machinery or equipment is used in an exempt manner under rules 701—230.14(423) to 701—230.20(423).

f. Exclusions. Sales of the following property, or materials used to construct or self-construct the following property, are not exempt under rules 701—230.14(423) to 701—230.20(423) regardless of how the property is used.

(1) Constructed realty.

1. Generally. Iowa Code section 423.2(1) “b” and “c” imposes sales and use tax upon building materials, supplies, and equipment used for the erection of buildings or other realty. However, Iowa Code section 423.3(47) exempts from sales and use tax certain computers, machinery, and equipment as well as items used to construct or self-construct certain computers, machinery, and equipment. Determining whether constructed items are realty or exempt computers, machinery, or equipment under Iowa Code section 423.3(47) ultimately depends on the use of the items. In general, exempt computers, machinery, and equipment under Iowa Code section 423.3(47) are tangible personal property when purchased, and they remain tangible personal property after installation. Materials used to construct realty remain taxable when purchased by the contractor, subcontractor, or builder under Iowa Code section 423.2(1) “b” and “c.” For more information about sales and use tax on construction activities, see 701—Chapter 219.

2. Distinguishing constructed realty from tangible personal property. For purposes of rules 701—230.14(423) to 701—230.22(423), an item remains tangible personal property after installation if all of the following apply:

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- The item can be removed without causing material damage or injury to the item or to the building that houses it or the real property upon which it is located;
 - The item does not bear the weight of a building or other realty;
 - The item does not in any other manner constitute an integral part of a building or other realty;
- and

- The item is used in an exempt manner under rules 701—230.14(423) to 701—230.20(423).

3. Buildings. Buildings are constructed realty. A “building” is any structure or edifice enclosing a space within its walls, and usually covered by a roof, the purpose of which is, for example, to provide shelter or housing for machinery or equipment or to provide working, office, parking, display, or sales space. Materials used to construct a building or any other realty are not exempt under rules 701—230.14(423) to 701—230.20(423), even if the realty is specially designed to house exempt computers, machinery, or equipment.

4. Examples.

- Property that, under normal conditions, remains tangible personal property after installation for purposes of rules 701—230.14(423) to 701—230.22(423) includes, but is not limited to:

- Storage tanks that rest upon a foundation and are secured with bolts.
- Industrial piping systems directly and primarily used in processing.
- Cooling towers directly and primarily used in processing.
- Structural steel, if exposed and used to support other computers, machinery, or equipment.

- Property that, under normal conditions, becomes constructed realty after installation for purposes of rules 701—230.14(423) to 701—230.22(423) includes, but is not limited to:

- Underground storage tanks constructed on site.
- Foundations made of concrete or other materials, regardless of whether they are used exclusively as platforms for machinery and equipment.

- Cooling towers primarily used to cool a building or other constructed realty.

- Structural steel, if used to construct a building or other constructed realty.

(2) Land.

(3) Intangible property.

(4) Hand tools. “Hand tool” means a tool that can be held in the hand or hands and is powered by human effort.

(5) Point-of-sale equipment and computers. “Point-of-sale equipment and computers” means input, output, and processing equipment used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and is located at the counter, desk, or other specific point where the transaction occurs.

(6) Certain centrally assessed industrial machinery, equipment, and computers. Property that is centrally assessed by the department of revenue under Iowa Code sections 428.24 to 428.29 or chapters 433, 434, 437, 437A, 437B, and 438 does not qualify for exemption under rules 701—230.14(423) to 701—230.20(423). Property used but not owned by persons whose property is defined by such provisions of the Iowa Code, which would be assessed by the department of revenue if the persons owned the property, also does not qualify for exemption under rules 701—230.14(423) to 701—230.20(423).

(7) Vehicles subject to registration. The general sales and use tax does not apply to vehicles subject to registration under Iowa Code chapter 321. Instead, such vehicles are subject to the fee for new registration under Iowa Code section 321.105A. Vehicles subject to registration are not exempt from the fee for new registration under rules 701—230.14(423) to 701—230.20(423), unless the vehicle is directly and primarily used in recycling or reprocessing of waste products (see rule 701—230.19(423)).

g. Examples. When used for an exempt purpose under rules 701—230.14(423) to 701—230.20(423), the following items may be exempt computers, machinery, or equipment. This list is not all-inclusive.

- (1) Coolers, including coolers that do not change the nature of materials stored in them.
- (2) Equipment that eliminates bacteria.
- (3) Palletizers.
- (4) Storage bins.

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- (5) Property used to transport raw, semifinished, or finished goods.
- (6) Vehicle-mounted cement mixers.
- (7) Self-constructed machinery and equipment.
- (8) Packaging and bagging equipment, including conveyer systems.
- (9) Equipment that maintains an environment necessary to preserve a product's integrity.
- (10) Equipment that maintains a product's integrity directly.
- (11) Quality control equipment.

230.14(3) *Leased and rented property.* The exemptions under rules 701—230.14(423) to 701—230.22(423) apply to property regardless of how it is sold, including leased or rented property. The lease of computers, machinery, or equipment may be exempt from sales and use tax if the lessee uses the property in an exempt manner under rules 701—230.14(423) to 701—230.20(423). Additionally, a lessor's purchase of computers, machinery, or equipment for lease may be an exempt sale for resale under Iowa Code section 423.3(2).

ITEM 9. Adopt the following **new** rule 701—230.15(423):

701—230.15(423) Exemption for the sale of property directly and primarily used in processing by a manufacturer if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used in processing by a manufacturer. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

230.15(1) *Required elements.* To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, or equipment (see subrule 230.14(2));
- b. Directly used (see subrule 230.15(2));
- c. Primarily used (see subrule 230.15(2));
- d. Used in processing (see subrule 230.15(3)); and
- e. Used by a manufacturer (see subrule 230.15(4)).

230.15(2) *Directly and primarily used.*

a. *Directly used.*

(1) Generally. Property is “directly used” only if it is used to initiate, sustain, or terminate an exempt activity. In determining whether any property is “directly used,” consideration should be given to the following factors:

1. The physical proximity of the property to the exempt activity;
2. The temporal proximity of the use of the property to the use of other property that is directly used in the exempt activity; and
3. The active causal relationship between the use of the property and the exempt activity. The fact that a particular piece of property may be essential to the conduct of the activity because its use is required either by law or practical necessity does not, of itself, mean that the property is directly used.

(2) Examples. The following property typically is not directly used in an exempt manner:

1. Property used exclusively for the comfort of workers, such as air cooling, air conditioning, or ventilation systems.
2. Property used in support operations, such as a machine shop, where production machinery is assembled, maintained, or repaired.
3. Property used by administrative, accounting, or personnel departments.
4. Property used by security, fire prevention, first aid, or hospital stations.
5. Property used in communications or safety.

b. *Primarily used.* The primary use of property is the activity or activities for which the property is used more than half of the time.

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230.15(3) Processing.

a. *Generally.* “Processing” means a series of operations in which materials are manufactured, refined, purified, created, combined, transformed, or stored by a manufacturer, ultimately into tangible personal property. Processing encompasses all activities commencing with the receipt or producing of raw materials by the manufacturer and ending at the point products are delivered for shipment or transferred from the manufacturer. Processing includes, but is not limited to, refinement or purification of materials; treatment of materials to change their form, context, or condition; maintenance of the quality or integrity of materials, components, or products; maintenance of environmental conditions necessary for materials, components, or products; quality control activities; construction of packaging and shipping devices; placement into shipping containers or any type of shipping device or medium; and the movement of materials, components, or products until shipment from the processor. “Receipt or producing of raw materials” means activities performed upon tangible personal property only. With respect to raw materials produced from or upon real estate, “production of raw materials” is deemed to occur immediately following the severance of the raw materials from the real estate.

b. *The beginning of processing.* Processing begins with a processor’s receipt or production of raw material. Thus, when a processor produces its own raw material, it is engaged in processing. Processing also begins when a supplier transfers possession of raw materials to a processor.

c. *The completion of processing.* Processing ends when the finished product is transferred from the processor or delivered for shipment by the processor. Therefore, a processor’s packaging, storage, and transport of a finished product after the product is in the form in which it will be sold at retail are part of the processing of the product.

d. *Examples of the beginning, intervening steps, and the ending of processing.* Of the following, Examples A and B illustrate when processing begins under various circumstances; Example C demonstrates the middle stages of processing; and Example D demonstrates when the end of processing takes place.

EXAMPLE A: Company A manufactures fine furniture. Company A owns a grove of walnut trees that it uses as raw material. Company A’s employees cut the trees, transport the logs to Company A’s facility, store the logs in a warehouse to begin the curing process, and eventually take the logs to Company A’s sawmill. The walnut trees are real property while they are growing. Thus, no “production of raw materials” has occurred with regard to the trees until they have been severed from the soil and transformed into logs. Processing of the logs begins when they are placed on vehicles for transport to Company A’s factory. However, if the transport vehicles are “vehicles subject to registration,” they are not exempt from the fee for new registration under this rule (see subparagraph 230.14(2)“f”(7)).

EXAMPLE B: Company A from the previous example also buys mahogany logs from a supplier in Honduras. Company A uses its equipment to offload the logs from railroad cars at its facility. Company A then stores and saws the logs as previously described in Example A. Processing begins when Company A offloads the logs from the railroad cars.

EXAMPLE C: Company C is a microbrewery. It uses a variety of kettles, vats, tanks, tubs, and other containers to mix, cook, ferment, settle, age, and store the beer it brews. Company C also uses a variety of pipes and pumps to move the beer among the various containers involved in the activity of brewing. All stages of this brewing are part of processing, including fermentation or aging (the transformation of the raw materials from one state to another) as well as the storage of hops in a bin and the storage of beer prior to bottling (the holding of materials in an existing state). Any movement of the product between containers is also a part of processing.

EXAMPLE D: After the brewing process is complete, Company C places its beer in various containers, stores the beer, and moves the beer to Company C’s customers by a common carrier that picks up the beer at Company C’s facility. Company C’s activities of placing the beer into bottles, cans, and kegs, storing it after packaging, and moving the beer by use of a forklift to the common carrier’s pickup site are part of processing.

230.15(4) Manufacturer.

a. *Generally.* “Manufacturer” means a person that purchases, receives, or holds personal property of any description for the purpose of adding to its value by a process of manufacturing, refining, purifying,

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or combining of different materials, or by the packing of meats, with a view to selling the property for gain or profit, but also includes contract manufacturers. A “contract manufacturer” is a manufacturer that otherwise falls within the definition of manufacturer, except that a contract manufacturer does not sell the tangible personal property the contract manufacturer processes on behalf of other manufacturers. A business engaged in activities subsequent to the extractive process of quarrying or mining, such as crushing, washing, sizing, or blending of aggregate materials, is a manufacturer with respect to these activities. A person does not need to be primarily engaged in an activity listed in this subrule in order to qualify as a manufacturer for purposes of this rule.

b. Nonexclusive examples. Those who are in the business of printing, newspaper publication, bookbinding, lumber milling, and production of drugs and agricultural supplies are illustrative, nonexclusive examples of manufacturers. Construction contracting; repairing of tangible personal property (such as automobile engines); provision of health care; farming; transportation for hire; and the activities of restaurateurs, hospitals, medical doctors, and those who merely process data are illustrative, nonexclusive examples of businesses that ordinarily are not manufacturers.

EXAMPLE A: Company A owns and operates a gravel pit. Company A sells the gravel extracted from the pit to others who use the gravel for surfacing roads and as an ingredient in concrete manufacture. Company A removes overlay and raw gravel from the pit and then transports the gravel to a plant where washing and sizing of the gravel take place. Company A is a manufacturer, but only with respect to those activities that occur after it extracts the gravel from the ground.

EXAMPLE B: Company B owns a manufacturing plant. Company B also owns a machine shop where it uses a metal press machine to fabricate patterns. All of these patterns are used in Company B’s manufacturing plant as part of processing, and the metal press machine is used solely to fabricate these patterns. The sales price of the metal press machine is not exempt from sales and use tax under this rule because Company B does not use the metal press machine to manufacture a product for sale at a gain or profit. However, the computers, machinery, and equipment in Company B’s manufacturing plant may be exempt if they are directly and primarily used in processing.

This rule is intended to implement Iowa Code section 423.3(47) “a”(1).

ITEM 10. Adopt the following new rule 701—230.16(423):

701—230.16(423) Exemption for the sale of property directly and primarily used by a manufacturer to maintain integrity or unique environmental conditions if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used to maintain the integrity of the product or to maintain unique environmental conditions required for either the product or the computers, machinery, and equipment used in processing by a manufacturer, including test equipment used to control quality and specifications of the product. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

230.16(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a.* Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, and equipment (see subrule 230.14(2));
- b.* Directly used (see subrule 230.15(2));
- c.* Primarily used (see subrule 230.15(2));
- d.* Used by a manufacturer (see subrule 230.15(4)); and
- e.* Used to maintain:
 - (1) A manufactured product’s integrity;
 - (2) Unique environmental conditions required for a manufactured product; or
 - (3) Unique environmental conditions required for other computers, machinery, or equipment directly and primarily used in processing by a manufacturer.

230.16(2) Example of property directly and primarily used to maintain integrity or unique environmental conditions. A manufacturer purchases a cooling tower to directly and primarily maintain

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the proper temperature of its machinery and equipment. The manufacturer uses such machinery and equipment directly and primarily in processing. Because the cooling tower maintains the environmental conditions necessary for machinery and equipment that is directly and primarily used in processing, the cooling tower and materials used to construct or self-construct the cooling tower are exempt from sales and use tax under this rule.

This rule is intended to implement Iowa Code section 423.3(47)“a”(2).

ITEM 11. Adopt the following new rule 701—230.17(423):

701—230.17(423) Exemption for the sale of property directly and primarily used in research and development of new products or processes of processing if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used in research and development of new products or processes of processing. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

230.17(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, and equipment (see subrule 230.14(2));
- b. Directly used (see subrules 230.15(2) and 230.17(3));
- c. Primarily used (see subrule 230.15(2)); and
- d. Used in research and development (see subrule 230.17(2)) of:
 - (1) New products; or
 - (2) Processes of processing.

230.17(2) “Research and development” means experimental or laboratory activity that has as its ultimate goal the development of new products or processes of processing.

230.17(3) Property is used “directly” in research and development only if it is used in actual experimental or laboratory activity that qualifies as research and development under this rule.

230.17(4) Example of property directly and primarily used in research and development of new products or processes of processing. A hybrid seed producer maintains a research and development laboratory for use in developing new varieties of corn seed. The hybrid seed producer purchases the following items for use in its research and development laboratory: a laboratory computer for processing data related to the genetic structure of various corn plants, an electron microscope for examining the structure of corn plant genes, a steam cleaner for cleaning rugs in the laboratory offices, and a desktop computer for use by the laboratory receptionist. The laboratory computer and the microscope are “directly” used in the research in which the laboratory is engaged; the steam cleaner and the receptionist’s computer are not directly used in research. Therefore, the sales prices of the laboratory computer and the microscope are exempt from sales and use tax. The sales prices of the steam cleaner and the receptionist’s computer are not exempt from tax under this rule.

This rule is intended to implement Iowa Code section 423.3(47)“a”(3).

ITEM 12. Adopt the following new rule 701—230.18(423):

701—230.18(423) Exemption for the sale of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of computers is exempt from sales tax when the computers are used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

230.18(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers (see paragraph 230.14(2)“a”);

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b. Used in processing or storage of data or information (see subrule 230.18(2)); and

c. Used by:

- (1) An insurance company (see subrule 230.18(3));
- (2) A financial institution (see subrule 230.18(3)); or
- (3) A commercial enterprise (see subrule 230.18(3)).

230.18(2) *Processing or storage of data or information.* All computers store and process information. However, only if the “final output” for a user or consumer is stored or processed data will the computer be eligible for exemption from tax under this rule.

230.18(3) *Insurance company, financial institution, or commercial enterprise.*

a. Insurance company. An insurance company is an insurer organized or operating under Iowa Code chapter 508, 514, 515, 518, 518A, 519, or 520 or an insurer authorized to do business in Iowa as an insurer or as a licensed insurance producer under Iowa Code chapter 522B. Excluded from the definition of “insurance company” are benevolent associations governed by Iowa Code chapter 512A, fraternal benefit societies governed by Iowa Code chapter 512B, and health maintenance organizations governed by Iowa Code chapter 514B. This list of exclusions is not intended to be exclusive.

b. Financial institution. A financial institution is any bank incorporated under the provisions of any state or federal law, any savings and loan association incorporated under the provisions of federal law, any credit union organized under the provisions of any state or federal law, any corporation licensed as an industrial loan company under Iowa Code chapter 536A, and any affiliate of a bank, savings and loan association, credit union, or industrial loan company.

c. Commercial enterprise. A commercial enterprise is a business or manufacturer conducted for profit, other than an insurance company or financial institution. “Commercial enterprise” includes centers for data processing services to insurance companies, financial institutions, businesses, and manufacturers, but excludes professions and occupations as well as nonprofit organizations. A hospital that is a not-for-profit organization is not a commercial enterprise. The term “profession” means a vocation or employment requiring specialized knowledge and often long and intensive academic preparation. The term “occupation” means the principal business of an individual, such as the business of farming. A professional entity that carries on any profession or occupation, such as an accounting firm, is not a commercial enterprise.

230.18(4) *Examples of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise.* A health insurance company has four computers. Computer A is used to monitor the temperature within the insurance company’s building. Computer A transmits messages to the building’s heating and cooling systems, which tell the systems when to raise or lower the level of heating or air conditioning. Computer B is used to store patient records and to recall those records on demand. Computer C is used to tabulate statistics regarding the amount of premiums paid in and the amount of benefits paid out for various classes of insured. Computer D is used to train the insurance company’s employees to perform various additional tasks or to better perform work the employees can already do. Computer D uses various canned programs to accomplish this function. The final output of Computer A is neither stored nor processed information. Therefore, Computer A does not meet the definition of an exempt computer. The final output of Computer B is stored information. The final output of Computer C is processed information. The final output of Computer D is processed information consisting of the training exercises appearing on the computer monitor. The sales prices of Computers B, C, and D are exempt from sales and use tax as computers used in processing or storage of data or information by an insurance company.

This rule is intended to implement Iowa Code section 423.3(47) “a”(4).

ITEM 13. Adopt the following new rule 701—230.19(423):

701—230.19(423) Exemption for the sale of property directly and primarily used in recycling or reprocessing of waste products if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of computers, machinery, and equipment, including replacement parts, and materials used to construct or self-construct computers, machinery, and equipment is exempt from sales and use tax when the property is directly and primarily used in recycling or reprocessing

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of waste products. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

230.19(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Computers, machinery, or equipment, including replacement parts, or materials used to construct or self-construct computers, machinery, and equipment (see subrule 230.14(2));
- b. Directly used (see subrule 230.15(2));
- c. Primarily used (see subrule 230.15(2)); and
- d. Used in:
 - (1) Recycling of waste products (see subrule 230.19(2)); or
 - (2) Reprocessing of waste products (see subrule 230.19(2)).

230.19(2) Recycling and reprocessing.

a. “Recycling” is any process by which waste or materials that would otherwise become waste are collected, separated, or processed and revised or returned for use in the form of raw materials or products. Recycling includes, but is not limited to, the composting of yard waste that has been previously separated from other waste. Recycling does not include any form of energy recovery.

b. “Reprocessing” is not a subcategory of processing. Reprocessing of waste products is an activity separate and independent from the processing of tangible personal property.

c. Recycling or reprocessing generally begins when the waste products are collected or separated. Recycling or reprocessing generally ends when waste products are in the form of raw material or another non-waste product. Activities that occur between these two points and are an integral part of recycling or processing qualify as recycling or reprocessing.

230.19(3) Examples.

a. Computers, machinery, and equipment that may be exempt from sales and use tax under this rule include, but are not limited to, compactors, balers, crushers, grinders, cutters, and shears if directly and primarily used in recycling or reprocessing.

b. End loaders, forklifts, trucks, conveyor systems, and other moving devices directly and primarily used in the movement of waste products during recycling or reprocessing may be exempt from sales and use tax under this rule.

c. A bin or other container used to store waste products before collection for recycling or reprocessing is not directly and primarily used in recycling or reprocessing, and its sales price is not exempt from sales and use tax under this rule.

d. A vehicle used directly and primarily for collecting waste products for recycling or reprocessing could be a vehicle used for an exempt purpose under this rule, and such a vehicle could be exempt from the fee for new registration. Thus, a garbage truck could qualify for this exemption if the truck is directly and primarily used in recycling; however, a garbage truck primarily used to haul garbage to a landfill does not qualify for exemption under this rule.

EXAMPLE A: Company A recycles household waste. Company A uses several machines in its facility to separate waste products into recyclable and nonrecyclable materials and to further separate the recyclable materials into paper, plastic, or glass. The sales prices of all separating machines are exempt from sales and use tax as machines directly and primarily used in recycling of waste products.

EXAMPLE B: Company B uses grinding machines to convert logs, stumps, pallets, crates, and other waste wood into wood chips. Company B then uses its trucks to deliver the wood chips to local purchasers. The sales prices of the grinding machines are exempt from sales and use tax as machines directly and primarily used in recycling or reprocessing of waste products. The trucks used to transport the wood chips are not used in recycling or reprocessing because the wood chips are in their final form when loaded onto the trucks.

This rule is intended to implement Iowa Code section 423.3(47)“a”(5).

ITEM 14. Adopt the following **new** rule 701—230.20(423):

701—230.20(423) Exemption for the sale of pollution control equipment used by a manufacturer if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of pollution

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control equipment, including but not limited to equipment required or certified by an agency of Iowa or of the United States government, is exempt from sales and use tax when the property is used by a manufacturer. For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

230.20(1) Required elements. To qualify for exemption under this rule, the purchaser must prove the property is:

- a. Pollution control equipment (See subrule 230.20(2)); and
- b. Used by a manufacturer (See subrule 230.15(4)).

230.20(2) “Pollution control equipment” is any disposal system or apparatus used or placed in operation primarily for the purpose of reducing, controlling, or eliminating air or water pollution. Pollution control equipment does not include any apparatus used to eliminate noise pollution. Liquid, solid, and gaseous wastes are included within the meaning of the word “pollution.” Pollution control equipment specifically includes, but is not limited to, any equipment the use of which is required or certified by an agency of this state or of the United States government. Wastewater treatment equipment, dust mitigation systems, and scrubbers used in smokestacks are examples of pollution control equipment. However, pollution control equipment does not include any equipment used only for worker safety, such as a gas mask.

EXAMPLE: A manufacturer constructs a wastewater treatment facility to treat wastewater from its manufacturing facility. The wastewater treatment facility uses aboveground piping and other equipment to divert wastewater from the local water treatment plant. The facility then converts wastewater into a biogas, which the manufacturer uses as an energy source in its manufacturing facility. The equipment used for the wastewater treatment facility is pollution control equipment used by a manufacturer. The sales price of the equipment is exempt from sales and use tax.

This rule is intended to implement Iowa Code section 423.3(47) “a”(6).

ITEM 15. Adopt the following new rule 701—230.21(423):

701—230.21(423) Exemption for the sale of fuel or electricity used in exempt property if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price of fuel or electricity consumed by property that is exempt from sales and use tax under rule 701—230.14(423), 701—230.15(423), 701—230.16(423), 701—230.17(423), 701—230.19(423), or 701—230.20(423) is also exempt from sales and use tax. The sales price of electricity or other fuel consumed by computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise remains subject to tax even if such computers are exempt under rule 701—230.18(423). For sales occurring as part of a contract entered into prior to July 1, 2016, see rule 701—18.58(422,423).

EXAMPLE: A manufacturer operates a power plant. The manufacturer uses energy from the power plant to operate machinery and equipment used directly and primarily in processing at its manufacturing facility. The fuel consumed in the manufacturer’s power plant is exempt from sales and use tax.

This rule is intended to implement Iowa Code section 423.3(47) “b.”

ITEM 16. Adopt the following new rule 701—230.22(423):

701—230.22(423) Exemption for the sale of services for designing or installing new industrial machinery or equipment if the sale occurs as part of a contract entered into on or after July 1, 2016. The sales price from the services of designing or installing new industrial machinery or equipment is exempt from sales and use tax. The enumerated services of electrical or electronic installation are included in this exemption.

230.22(1) Required elements. To qualify for the exemption, the purchaser must prove the service is:

- a. A design or installation service (see subrule 230.22(2));
- b. Of new (see subrule 230.22(3)); and
- c. Industrial machinery or equipment (see subrule 230.22(4)).

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230.22(2) Design or installation services include electrical and electronic installation. “Design or installation” services do not include any repair service.

230.22(3) “New” means never having been used or consumed by anyone. The exemption does not apply to design or installation services on reconstructed, rebuilt, repaired, or previously owned machinery or equipment.

230.22(4) Industrial machinery or equipment.

a. Generally. “Industrial machinery or equipment” means machinery or equipment, as defined in subrule 230.14(2). The sale of industrial machinery or equipment must also qualify for exemption under any of the following:

(1) Property used directly and primarily in processing by a manufacturer (see rule 701—230.15(423)).

(2) Property used directly and primarily by a manufacturer to maintain the integrity of the manufacturer’s product or to maintain unique environmental conditions for computers, machinery, or equipment (see rule 701—230.16(423)).

(3) Property used directly and primarily in research and development of new products or processes of processing (see rule 701—230.17(423)).

(4) Property used directly and primarily in recycling or reprocessing of waste products (see rule 701—230.19(423)).

(5) Pollution control equipment used by a manufacturer (see rule 701—230.20(423)).

b. Exclusions. The following property is not industrial machinery or equipment regardless of how the purchaser uses it:

(1) Computers (see paragraph 230.14(2) “a”).

(2) Supplies, including but not limited to drill bits, grinding wheels, punches, taps, reamers, saw blades, lubricants, coolants, sanding discs, sanding belts, and air filters.

(3) Replacement parts (see paragraph 230.14(2) “d”).

230.22(5) Billing. The sales price for designing or installing new industrial machinery or equipment must be separately identified, charged separately, and reasonable in amount for the exemption to apply. The exemption applies to new industrial machinery or equipment regardless of how it is purchased, including leased or rented machinery or equipment.

EXAMPLE: Dealer sells and installs two new machines for Manufacturer. Manufacturer uses one machine on its production floor, where it is directly and primarily used in processing. Manufacturer uses the other machine in its machine shop, where it is not directly and primarily used in processing. Dealer gives an invoice to Manufacturer that separately itemizes the sales prices for each machine and each installation. The machine used on the production floor is new industrial machinery or equipment, and the sales prices of the machine and its installation are exempt from sales and use tax. The machine used in the machine shop is not new industrial machinery or equipment, and the sales prices of the machine and its installation are taxable.

This rule is intended to implement Iowa Code section 423.3(48).

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STATE PUBLIC DEFENDER[493]

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 13B.4(8), the State Public Defender hereby gives Notice of Intended Action to amend Chapter 1, “Administration,” Chapter 11, “Attorney Fee Contracts,”

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Chapter 12, "Claims for Indigent Defense Services," and Chapter 13, "Claims for Other Professional Services," Iowa Administrative Code.

These proposed amendments establish measures to promote fairness in the review of claims of contract attorneys and other professionals who render services on behalf of indigent clients. These measures include:

1. Adding an "undue burden" exception to the enforcement of the 45-day time limit for the submission of attorney fee claims;
2. Changing the current rule providing that any attorney fees "shall be denied" in the event of noncompliance with the State Public Defender's attorney designation to read that attorney fees "may be denied, in whole or in part" in the event of noncompliance;
3. Expanding the circumstances in which substitute counsel will be permitted;
4. Increasing the threshold amount before a parking receipt is required for reimbursement to attorneys;
5. Allowing court interpreters' claims for payment to be timely if submitted within 45 days of the court order approving payment;
6. Excluding weekends and state holidays from the calculation of the 24-hour prior notice required before a deposition can be canceled without cancellation fees to the court reporter;
7. Allowing and requiring additional process for attorney claimants under certain circumstances; and
8. Allowing the State Public Defender additional discretion in determining whether minimum qualification requirements are sufficient for an attorney to contract to accept court appointments in felony cases.

The proposed amendments also make other technical and substantive revisions to promote fairness in the claims review process. In addition, the proposed amendments conform the types of misdemeanor cases for indigent persons to whom the state public defender system provides representation to the Iowa Supreme Court decision in *State v. Young*, 863 N.W.2d 249 (Iowa 2015) and extend the purposes for which evaluations may be court ordered to conform with the Iowa Supreme Court decision in *State v. Lyle*, 854 N.W. 2d 378 (Iowa 2014).

Any interested person may make written suggestions or comments on the proposed amendments on or before December 4, 2015. Such written comments should be sent to Kurt Swaim, First Assistant State Public Defender, Fourth Floor, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319; by fax to (515)281-7289; or e-mail to kswaim@spd.state.ia.us.

A public hearing will be held on December 4, 2015, at 10 a.m. in Conference Room 424, Fourth Floor, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa, at which time persons may present their views 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 of the amendments.

Any persons who intend to attend the hearing and have special requirements, such as those related to hearing or mobility impairments, should contact the State Public Defender and advise of specific needs.

The Agency does not believe that the proposed amendments pose a financial hardship on any regulated entity or individual.

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

These amendments are intended to implement Iowa Code chapters 13B and 815.

The following amendments are proposed.

ITEM 1. Amend paragraph **1.3(2)“b”** as follows:

b. Misdemeanors, if ~~there exists a potential for jail sentence~~ an accused faces the possibility of imprisonment under the applicable criminal statute;

ITEM 2. Amend subrule 11.3(4) as follows:

11.3(4) Class A and B felonies. To be eligible to contract to represent indigent persons in Class A and Class B felony cases at the trial level, an attorney must:

- a.* Have practiced criminal law for four years or more in any state or federal court;

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b. Have tried at least five criminal jury trials to completion either as lead counsel or as a pro bono second attorney in a criminal jury trial if the service as pro bono second attorney is approved in advance for credit under this rule by the state public defender;

c. Participate in five hours of continuing legal education related to criminal law each calendar year in which the attorney has an active indigent defense contract and in the year prior to entering into the contract; and

d. Provide the names of at least three judges or magistrates who can discuss the qualifications and effectiveness of the attorney to represent indigent persons in Class A and Class B felony cases.

If an attorney satisfies the requirements for Class C and Class D felonies, the attorney may contract to serve as the second attorney representing an indigent person in a Class A felony in a case where the first appointed attorney meets these requirements. An attorney who does not meet all the requirements of this subrule ~~but who has previously tried a Class A or Class B felony case to completion as lead counsel~~ may provide the state public defender additional detail regarding the attorney's experience and qualifications and the circumstances preventing the attorney from meeting all the requirements and may be approved for contracting by the state public defender at the state public defender's sole discretion.

ITEM 3. Amend subrule 11.3(5) as follows:

11.3(5) Class C and D felonies. To be eligible to contract to represent indigent persons in Class C and Class D felony cases at the trial level, an attorney must:

a. Have practiced criminal law for two years or more in any state or federal court;

b. Have tried at least one criminal jury trial to completion either as lead counsel or as a pro bono second attorney in a criminal jury trial if the service as pro bono second attorney is approved in advance for credit under this rule by the state public defender;

c. Participate in five hours of continuing legal education related to criminal law each calendar year in which the attorney has an active indigent defense contract and in the year prior to entering into the contract; and

d. Provide the names of at least three judges or magistrates who can discuss the qualifications and effectiveness of the attorney to represent indigent persons in felony cases.

An attorney who has not met all requirements ~~except for the jury trial requirement set forth in paragraph 11.3(5)“b”~~ may provide the state public defender additional detail regarding the attorney's experience and qualifications and the circumstances preventing the attorney from ~~obtaining jury trial experience meeting all the requirements~~ and may be approved for contracting by the state public defender at the state public defender's sole discretion.

ITEM 4. Amend paragraph **11.7(2)“c”** as follows:

c. Improper billing practices. The state public defender may notify the attorney that the state public defender is considering the exercise of the state public defender's contract right to terminate the contract for improper billing practices. The notification shall explain the basis for the state public defender's concern and provide the attorney at least 14 days to provide a response. After consideration of the response, the state public defender may terminate the contract for improper billing practices if the state public defender determines that the attorney has engaged in a pattern of willful, intentional, reckless, or negligent submission of false, abusive, or unreasonably excessive fee claims. An attorney may seek reconsideration of the state public defender's decision to terminate a contract for improper billing practices in the manner described in rule 493—11.9(13B).

ITEM 5. Amend subrule 11.9(1) as follows:

11.9(1) Written notice. A request for reconsideration is perfected by giving written notice of the request for reconsideration to the state public defender within ten business days of the date of mailing of the notice of denial of an initial or renewal contract, or the notice of termination ~~following issuance of a notice of default~~. A request for reconsideration must be in writing and must specify the factual or legal errors the attorney contends were made by the state public defender. The attorney may provide such additional information, explanation or documentation as the attorney believes would be relevant to the reconsideration decision. The request for reconsideration is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service on the state public defender.

STATE PUBLIC DEFENDER[493](cont'd)

ITEM 6. Amend subrule 11.9(2) as follows:

11.9(2) Exhaustion of administrative remedies. A request for reconsideration of the state public defender's decision to deny or terminate a contract ~~for cause~~ is an administrative prerequisite to seeking any form of judicial review pursuant to Iowa Code chapter 17A.

ITEM 7. Amend subrule 12.2(3) as follows:

12.2(3) Timely claims required. Claims submitted prior to the date of service shall be returned to the claimant unpaid and may be resubmitted to the state public defender after the date of service. Claims that are not submitted within 45 days of the date of service as defined in this subrule ~~shall~~ may be denied, in whole or in part, as untimely unless the delay in submitting the claim is excused by paragraph 12.2(3) "*f*." Attorney fees and expenses that are submitted on a claim denied as untimely under this subrule may be resubmitted on a subsequent claim that is timely submitted with respect to a subsequent date of service in the same case. For purposes of this subrule, a probation, parole, or contempt proceeding is not the "same case" as the underlying proceeding.

a. Adult claims. For adult claims, "date of service" means the date of filing of an order indicating that the case was dismissed or the client was acquitted or sentenced, the date of a final order in a postconviction relief case, the date of mistrial, the date on which a warrant was issued for the client, or the date of a court order authorizing the attorney's withdrawal from a case prior to the date of a dismissal, acquittal, sentencing, or mistrial or the issuance of a warrant. The filing of a notice of appeal is not a date of service. If a motion for reconsideration is filed, the date on which the court rules on that motion is the date of service. For interim adult claims authorized by subrule 12.3(3) or 12.3(4), the date of service is the last day on which the attorney claimed time on the itemization of services.

b. Juvenile claims. For juvenile claims, "date of service" means the date of filing of an order as a result of the dispositional hearing or most recent postdispositional hearing that occurs while the client is still an active party in the case, the date on which the client ceased to be a party, the date of a court order authorizing the attorney's withdrawal from a case prior to the filing of the final ruling with respect to the client, the date jurisdiction is waived to adult court, the date on which the venue is changed, the date of dismissal, or the file-stamped date of a procedendo resulting from a petition on appeal. The date of a family drug court meeting, family team meeting, staffing, or foster care review board hearing is not a date of service.

c. Appellate claims. For appellate claims, "date of service" means the date on which the case was dismissed, the date of a court order authorizing the attorney's withdrawal prior to the filing of the proof brief, the date on which the proof brief was filed, or the date on which the procedendo was issued.

d. Notices of action and returned claims. For claims of any type that are filed as a result of a notice of action letter or a returned fee claim letter, "date of service" means the date of the notice of action letter or returned fee claim letter. But a claim that is denied as untimely does not become timely merely because it was resubmitted within 45 days of a returned fee claim letter. A timely claim returned to the attorney for additional information shall continue to be deemed timely only if resubmitted with the required information within 45 days of being returned by the state public defender.

e. Court orders. For claims of any type that are filed as a result of a court order after hearing for review of the fee claim, "date of service" means the file-stamped date of the order.

f. Exceptions to the 45-day rule. The state public defender may in the state public defender's sole discretion approve a claim that was not submitted within 45 days of the date of service only if the delay in submitting the claim was caused by one of the following circumstances:

- (1) The death of the attorney;
- (2) The death of the spouse of the attorney, a child of the attorney, or an employee of the attorney who was responsible for assisting in the preparation of the attorney's fee claims;
- (3) A serious illness, injury, or other medical condition that prevents the attorney from working for more than 3 consecutive days and occurs in the last 5 days before the expiration of the 45-day period for timely claims;
- (4) The attorney's need to care for the attorney's spouse or child with a serious illness, injury, or other medical condition that prevents the spouse or child from working, attending school, or performing

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other regular daily activities for more than 3 consecutive days and occurs in the last 5 days before the expiration of the 45-day period for timely claims.

(5) Other circumstances in which the state public defender determines, in the sole discretion of the state public defender, that enforcement of the 45-day rule would impose an undue burden and that payment of the claim should in fairness be made, in whole or in part. The state public defender, in the exercise of such discretion, may consider factors including, but not limited to:

1. The extent to which the 45-day rule was violated;
2. The justification provided by the attorney;
3. The attorney's claim history;
4. The extent of prejudice likely to be experienced by the attorney, the state public defender, and any party to the proceeding, including the attorney's client.

Any claim submitted pursuant to subparagraph (1) must be submitted within 45 days of the death of the attorney. Any claim submitted pursuant to subparagraph (2) must be submitted within 30 days of the death that caused the delay. Any claim submitted pursuant to subparagraph (3) or (4) must be submitted within 15 days of the end of the illness, injury, or medical condition that caused the delay. An attorney claiming an exception to the 45-day rule shall submit with the claim a letter explaining the applicable exception and written documentation supporting the exception.

ITEM 8. Amend subrule 12.2(4) as follows:

12.2(4) *Valid appointment required.* Claims for compensation from an attorney appointed as counsel or guardian ad litem may be denied if the attorney was appointed contrary to Iowa Code section 814.11 or 815.10. Claims for which court-appointed counsel at state expense is not statutorily authorized or which are not payable from the indigent defense fund created by Iowa Code section 815.11 shall be denied.

a. Appellate appointments. Claims for compensation from an attorney whose appointment as counsel or guardian ad litem at the appellate level does not comply with Iowa Code section 814.11 shall may be denied in whole or in part.

b. Trial-level designations. Claims by an attorney whose appointment in a case as counsel or guardian ad litem at the trial level was made on or after July 1, 2009, shall may be denied in whole or in part if the state public defender filed a designation effective at the time of the appointment designating a local public defender, nonprofit corporation, or attorney to represent indigent persons in that type of case in the county in which the case was filed, unless the appointment order and any supporting documentation submitted with the claim demonstrate that:

- (1) The state public defender's designee and any successor designee have withdrawn from the case or have been offered and declined to take the case; or
- (2) The state public defender's designee and any successor designee would have withdrawn from or would have declined to take the case had the appointment been offered.

c. Trial-level contract attorney preference. Claims by an attorney whose appointment in a case as counsel or guardian ad litem at the trial level was made on or after February 1, 2012, shall may be denied in whole or in part unless:

- (1) At the time of the appointment, the attorney had a contract with the state public defender to represent indigent persons in that specific type of case and that county in which the action was pending; or
- (2) The appointment order includes a specific finding that no attorney with a contract to represent indigent persons in that specific type of case and that county in which the action was pending is available or a finding that the state public defender was consulted and consented to the appointment; or
- (3) After the appointment, the attorney entered into a contract with the state public defender, or amended the attorney's existing contract, to represent indigent persons in the specific type of case and the county in which the action was pending, in which case only the portion of the claim for the services performed prior to the effective date of the contract shall be denied.

ITEM 9. Amend subrule 12.5(5) as follows:

12.5(5) *Substitute counsel time.* Work performed by substitute counsel on behalf of an attorney appointed as counsel or guardian ad litem is payable only as provided for under this subrule. The

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appointed attorney is at all times personally responsible for the representation of the client and must ensure that substitute counsel is qualified to perform the work directed and that the client is effectively represented at all times. The appointed attorney is responsible for compensating substitute counsel. Claims for payment directly by substitute counsel or claims for payment by the appointed attorney that are inconsistent with this subrule shall be denied.

a. Court time. An attorney appointed as counsel or guardian ad litem must handle all court appearances unless the appointed attorney has ~~an unavoidable~~ a scheduling conflict, an illness, or other personal emergency, in which case the matter may be covered by substitute counsel. ~~Unless substitute counsel appears for the sole purpose of alerting the court of the appointed attorney's unavailability and requesting a continuance, substitute counsel may not cover for the appointed attorney at a trial in any criminal, juvenile, or postconviction relief case, or in any other hearing in which the court determines that the appointed attorney's personal participation is required.~~ Substitute counsel may never cover for oral arguments in appellate cases.

b. Out-of-court time. Substitute counsel ~~must not~~ may perform out-of-court legal services, except that substitute counsel may perform out-of-court legal services to prepare for handling a payable court appearance, and in a juvenile case, substitute counsel may attend a department of human services staffing or family team meeting if appointed counsel has an unavoidable scheduling conflict, illness, or other personal emergency. Time time spent by substitute counsel that duplicates work performed by the appointed attorney and time spent receiving direction from or conferencing with the appointed attorney is are not payable.

c. Exceptional circumstances. Substitute counsel may be used in situations that would otherwise be impermissible if the state public defender concludes that use of such substitute counsel would be in the best interest of the client and the administration of justice and provides prior written consent to the appointed attorney.

d. Supervisory time. Time spent by the appointed attorney directing, reviewing, or correcting the work of substitute counsel is not payable.

e. Qualification of substitute counsel. Unless the state public defender has given prior written consent to use the attorney as substitute counsel, substitute counsel must have an active contract with the state public defender to perform indigent defense services, although the contract need not cover the type of case or county of the case for which the claim is submitted.

f. Inapplicability to co-counsel in Class A felonies. The previous paragraphs of this subrule do not apply to a co-counsel who is separately appointed in a Class A felony. Each separately appointed co-counsel in a Class A felony shall submit a separate indigent defense fee claim that claims only the work actually performed by the appointed attorney submitting the claim. The use of substitute counsel is not permissible in a Class A felony in which co-counsel has been separately appointed.

ITEM 10. Amend paragraph **12.8(1)**"e" as follows:

e. Ordinary and necessary postage, toll calls, collect calls, and parking for the actual cost of these expenses. Toll and collect calls will be reimbursed at 10 cents per minute or the actual cost. A receipt for the actual cost of the toll or collect call must be attached to the claim form. A statement from a correctional facility or jail detailing a standard rate for such calls shall constitute a receipt for purposes of this paragraph. For parking expenses in excess of \$2 ~~\$5~~, a receipt must be attached to the claim form. Claims for the cost of a parking ticket shall be denied. Unless a receipt is provided, any postage, toll calls, collect calls, or parking expenses shall be separately itemized on the itemization of services, specifying the date on which the expense was incurred and, if it is not otherwise clear from the itemization, the purpose of the expense.

ITEM 11. Amend paragraph **13.2(2)**"c" as follows:

c. One copy of each of the following documents is attached to the claim:

(1) The application and order appointing the interpreter. This appointment is presumed to continue until the conclusion of the matter, unless limited by the court or modified by a subsequent order.

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(2) The order appointing counsel. This order is unnecessary if the attorney is not court-appointed but the court, in granting the application for the appointment of the interpreter, makes one of the following specific findings:

1. The client is indigent, or

2. Although the client is able to employ counsel, funds are not available to the client to pay for necessary interpreter services.

(3) An itemization of the interpreter's services detailing the expenses incurred, the services rendered, the date(s) on which the services were rendered, the time spent on each date including the time services began and ended on each day, and the manner in which the amount of the claim for services was calculated. With regard to expenses and services, the following shall apply:

1. Receipts for parking expenses are ~~required for actual costs of \$2 or more per day~~ reimbursed pursuant to the Judicial Branch Administrative Directive on Court Interpreter and Translator Compensation Policies.

2. Claims for translating documents will be paid ~~by the hour, not by the word or line~~ pursuant to the Judicial Branch Administrative Directive on Court Interpreter and Translator Compensation Policies.

(4) A court order setting the maximum dollar amount of the claim.

ITEM 12. Amend paragraph **13.2(2)“d”** as follows:

d. Timely claims required. Claims for services are timely if, within 45 days of completion of services, either the claim is submitted to the state public defender for payment within 45 days of completion of services or the Fee Itemization Form and Court Order Approving Claim for Court Interpreter Services is filed with the clerk of court in the case. Claims that are not timely submitted shall be denied.

ITEM 13. Amend subparagraph **13.2(4)“d”(6)** as follows:

(6) Cancellation fees. No cancellation fees will be paid as long as the certified shorthand reporter is given notice of cancellation at least 24 hours before the time scheduled for a deposition. Weekends and state holidays shall not be included when calculating the 24-hour prior notice of cancellation contained in this subparagraph. If the deposition is canceled with less than 24 hours' notice, a fee for two hours or the actual time that the certified shorthand reporter is present at the site of the deposition including setup and takedown of equipment, whichever is greater, is payable at the rate set forth in subparagraph 13.2(4)“d”(1). A certified shorthand reporter is deemed to have been given notice of cancellation when an attorney or representative of the attorney delivers notice of a cancellation to the e-mail address provided by the certified shorthand reporter or leaves a message on voicemail or with a representative of the certified shorthand reporter at the telephone number provided by the certified shorthand reporter, not when the certified shorthand reporter actually hears or reads the message. No cancellation fee will be paid related to the transcription of an audio or video recording.

ITEM 14. Amend subrule 13.2(5) as follows:

13.2(5) Claims for court-ordered evaluations. The state public defender shall review, approve and forward for payment claims for necessary and reasonable evaluations requested by an appointed attorney only if the purpose of the evaluation is to establish a defense, ~~or~~ to determine whether an indigent is competent to stand trial, or to evaluate a defendant at sentencing or resentencing who has been charged as an adult for a felony alleged to have been committed while a juvenile, if the offense has a potential mandatory minimum sentence of imprisonment, and not for any other purpose such as nor in any other circumstance for sentencing or placement. Additionally, a claim for a court-ordered evaluation will be approved only if the following conditions are met:

a. The person performing the evaluation submits a signed original and one copy of a claim containing the following information:

(1) The case name, case number and county in which the action is pending.

(2) The name of the attorney for whom the services were provided.

(3) The date on which services commenced.

(4) The date on which services ended.

(5) The total number of hours claimed.

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- (6) The total amount of the claim.
- (7) The claimant's name, address, social security number or federal tax identification number, and telephone number.
 - b. Court approval to conduct the evaluation was obtained before any expenses for the evaluation were incurred.
 - c. One copy of each of the following documents is attached to the claim:
 - (1) The application and order granting authority to conduct the evaluation. This order must specify that the purpose of the evaluation is ~~either to establish a defense to a pending charge or to determine whether an indigent is competent to stand trial for a permissible purpose under this subrule.~~
 - (2) The order appointing counsel. This order is unnecessary if the attorney is not court-appointed but the court, in granting the application noted above, determines that, although the client is able to employ counsel, funds are not available to the client to pay for the evaluation.
 - (3) An itemization of the evaluator's services detailing the expenses incurred, the services rendered, the date(s) on which the services were rendered, the time spent on each date, and the manner in which the amount of the claim for services was calculated.
 - (4) A court order setting the maximum dollar amount of the claim. For purposes of this subrule, if the court order authorizing the evaluation sets a limit for the claim, this court order is unnecessary.
 - (5) If the evaluator charges a "minimum" amount for services based on a specific time, a certification by the evaluator that no other services have been performed or charges made by the evaluator for any portion of that specific time.

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:

November 1, 2014 — November 30, 2014	4.50%
December 1, 2014 — December 31, 2014	4.25%
January 1, 2015 — January 31, 2015	4.25%
February 1, 2015 — February 28, 2015	4.25%
March 1, 2015 — March 31, 2015	4.00%
April 1, 2015 — April 30, 2015	4.00%
May 1, 2015 — May 31, 2015	4.00%
June 1, 2015 — June 30, 2015	4.00%
July 1, 2015 — July 31, 2015	4.25%
August 1, 2015 — August 31, 2015	4.25%
September 1, 2015 — September 30, 2015	4.25%
October 1, 2015 — October 31, 2015	4.25%
November 1, 2015 — November 30, 2015	4.25%

ARC 2229C

EDUCATIONAL EXAMINERS BOARD[282]

Adopted and Filed

Pursuant to the authority of Iowa Code section 272.2(2), the Board of Educational Examiners hereby amends Chapter 12, "Fees," Iowa Administrative Code.

During the 2015 legislative session, the General Assembly passed 2015 Iowa Acts, House File 658, section 52, which transfers \$600,000 to the Department of Education from the Board of Educational Examiners in order to pay for the "I Have a Plan Iowa" software. The appropriation of these funds will leave the Board with a cash balance of approximately \$550,000 to start fiscal year 2016.

In light of these developments, the Board hereby adopts an amendment that increases all licensure fees by \$4. Raising the fees will provide the Board with additional dollars to rebuild the Board's cash reserves and enhance its revenue stream as the agency anticipates increased expenses that will exceed existing revenue in future fiscal years if revenues are not increased. The last time the Board raised fees was in 2005 when the Board raised typical licensure fees from \$60 to \$85.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2131C** on September 2, 2015. A public hearing took place on September 23, 2015. No one attended the public hearing. The Board received one written comment from the Iowa State Education Association in opposition to the amendment. This amendment is identical to that published under Notice of Intended Action.

This amendment is subject to waiver pursuant to 282—Chapter 6.

The Board of Educational Examiners adopted this amendment on October 9, 2015.

After analysis and review of this rule making, there is no anticipated impact on jobs.

This amendment is intended to implement Iowa Code section 272.2(2).

This amendment will become effective December 16, 2015.

The following amendment is adopted.

Amend **282—Chapter 12** as follows:

CHAPTER 12
FEES

282—12.1(272) Issuance of licenses, certificates, authorizations, and statements of professional recognition. All application and licensure fees are nonrefundable. The fee for the issuance of a license, certificate, statement of professional recognition, or authorization shall be ~~\$85~~ \$89 unless otherwise specified below:

1. Class E emergency license shall be ~~\$150~~ \$154.
2. Paraeducator certificate shall be ~~\$40~~ \$44.
3. Behind-the-wheel authorization shall be ~~\$40~~ \$44.

282—12.2(272) Fees for the renewal or extension of licenses, certificates, statements of professional recognition, and authorizations. The fee for the renewal or extension of a license, certificate, statement of professional recognition, or authorization shall be ~~\$85~~ \$89 unless otherwise specified below:

1. The renewal of the paraeducator certificate shall be ~~\$40~~ \$44.
2. The renewal of the behind-the-wheel authorization shall be ~~\$40~~ \$44.
3. A one-year extension for renewal of a coaching authorization shall be ~~\$40~~ \$44.
4. A one-year extension of the initial license shall be ~~\$25~~ \$29. This extension may be issued if the applicant needs one additional year to meet the experience requirement for the standard license, but has met Iowa teaching standards, pursuant to rule 282—20.4(272).

5. A ~~\$25~~ \$29 fee for an extension of the initial administrator license, which may be issued instead of renewing the initial administrator license if the applicant verifies one of the criteria listed in 282—subrule 20.8(2).

EDUCATIONAL EXAMINERS BOARD[282](cont'd)

282—12.3(272) Evaluation fee. Each application from an out-of-state institution for initial licensure shall include, in addition to the basic fee for the issuance of a license, a one-time nonrefundable ~~\$60~~ \$64 evaluation fee. Each application or request for a statement of professional recognition shall include a one-time nonrefundable ~~\$60~~ \$64 evaluation fee.

282—12.4(272) Adding endorsements.

12.4(1) Fee for each added endorsement. The fee for each additional endorsement to a license following the issuance of the initial license and endorsement(s) shall be ~~\$50~~ \$54. The fee for each additional endorsement added to a paraeducator certificate shall be ~~\$25~~ \$29.

12.4(2) Fee for transcript review. Applicants may ask the board of educational examiners to analyze transcripts if the applicant believes all requirements have been met. Applicants who request board of educational examiners transcript analysis shall be assessed a ~~\$60~~ \$64 transcript evaluation fee for each new endorsement requested. This fee shall be in addition to the fee for adding the endorsement.

282—12.5(272) Duplicate licenses, authorizations, and statements of professional recognition. The fee for the issuance of a duplicate practitioner's license, certificate, statement of professional recognition, or authorization shall be ~~\$15~~ \$19.

282—12.6(272) Late fees.

12.6(1) An additional fee of ~~\$25~~ \$29 per calendar month, not to exceed ~~\$150~~ \$174, shall be imposed if an application for renewal or conversion of a Class A, B, or E license or a statement of professional recognition (SPR) is submitted after the date of expiration of a practitioner's license. Waiver of the late fee will be granted only upon a showing of extraordinary circumstances rendering imposition of the fee unreasonable.

12.6(2) Failure to hold an endorsement. An additional fee of ~~\$25~~ \$29 per calendar month, not to exceed ~~\$150~~ \$174, shall be imposed if the practitioner holds a valid Iowa license, but does not hold an endorsement for the type of service for which the practitioner is employed.

12.6(3) Failure to hold valid Iowa license or authorization. An additional fee of ~~\$100~~ \$104 per calendar month, not to exceed ~~\$500~~ \$520, shall be imposed if the practitioner does not hold a valid Iowa license or authorization. The fee will begin to be assessed on the first day of the school year for which the practitioner is employed until the practitioner submits a completed application packet for the appropriate license. The penalty will enforce Iowa Code section 272.7. Waiver of the fee will be granted only upon a showing of extraordinary circumstances rendering imposition of the fee unreasonable.

282—12.7(272) No change.

282—12.8(272) Portfolio review and evaluation fees. The fee for review and evaluation of an applicant portfolio is set as follows:

12.8(1) For the professional education core, the portfolio review and evaluation fee shall be ~~\$500~~ \$504.

12.8(2) For content endorsement, the portfolio review and evaluation fee shall be ~~\$250~~ \$254.

282—12.9(272) No change.

These rules are intended to implement Iowa Code chapter 272.

[Filed 10/12/15, effective 12/16/15]

[Published 11/11/15]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/11/15.

ARC 2230C**EDUCATIONAL EXAMINERS BOARD[282]****Adopted and Filed**

Pursuant to the authority of Iowa Code section 272.2(17), the Board of Educational Examiners hereby amends Chapter 13, "Issuance of Teacher Licenses and Endorsements," Chapter 15, "Special Education Support Personnel Authorizations," Chapter 16, "Statements of Professional Recognition (SPR)," Chapter 18, "Issuance of Administrator Licenses and Endorsements," Chapter 20, "Renewals," Chapter 22, "Authorizations," Chapter 23, "Behind-the-Wheel Driving Instructor Authorization," Chapter 24, "Paraeducator Certificates," and Chapter 27, "Issuance of Professional Service Licenses," Iowa Administrative Code.

The amendments update administrative rules to reflect changes to Iowa Code section 272.2(17), which was amended by 2015 Iowa Acts, Senate File 131, regarding the review of information in the Iowa court information system during background checks. The amendments also streamline several rules by creating a single reference for all background check procedures.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2130C** on September 2, 2015. A public hearing was held on September 23, 2015. No one attended the public hearing, and no written comments were received. These amendments are identical to those published under Notice of Intended Action.

These amendments are subject to waiver pursuant to 282—Chapter 6.

The Board of Educational Examiners adopted these amendments on October 9, 2015.

After analysis and review of this rule making, there is no anticipated impact on jobs.

These amendments are intended to implement Iowa Code section 272.2(17).

These amendments will become effective December 16, 2015.

The following amendments are adopted.

ITEM 1. Amend rule 282—13.1(272) as follows:

282—13.1(272) All applicants desiring Iowa licensure.

13.1(1) *Licenses, authorizations, certificates, and statements of professional recognition.* Licenses, authorizations, certificates, and statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

~~13.1(1)~~ *a. National criminal history background check.* An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

~~13.1(2)~~ *b. Iowa division of criminal investigation background check.* An Iowa division of criminal investigation (DCI) background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

c. Registries and records check. A check of the following registries and records will be conducted on initial applicants: the sex offender registry under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the information in the Iowa court information system available to the general public. The fee for checks of these registries and records will be assessed to the applicant.

~~13.1(3)~~ **13.1(2)** *Temporary permits.* The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check. The temporary permit shall serve as evidence of the applicant's authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license,

EDUCATIONAL EXAMINERS BOARD[282](cont'd)

certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

ITEM 2. Adopt the following **new** subparagraph **15.7(6)“b”(6)**:

(6) Have completed the background check requirements set forth in rule 282—13.1(272).

ITEM 3. Amend rule 282—16.1(272) as follows:

282—16.1(272) Statement of professional recognition (SPR).

16.1(1) The following are authorizations requiring or permitting statements of professional recognition and licenses obtained from the professional licensure division, department of public health, or the board of nursing:

- 1- a. School audiologist.
- 2- b. School nurse.
- 3- c. School occupational therapist.
- 4- d. School physical therapist.
- 5- e. School social worker.
- 6- f. Special education nurse.
- 7- g. Speech-language pathologist.

16.1(2) Application. Statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the background check requirements set forth in rule 282—13.1(272).

ITEM 4. Amend rule 282—18.1(272) as follows:

282—18.1(272) All applicants desiring an Iowa administrator license.

18.1(1) Administrator licenses. Administrator licenses are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

18.1(1) National criminal history background check. An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant. the background check requirements set forth in rule 282—13.1(272).

18.1(2) Iowa division of criminal investigation background check. An Iowa division of criminal investigation background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

18.1(3) **18.1(2)** Temporary permits. The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application, including certification from the applicant of completion of the Praxis II examination, if required; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check. The temporary permit shall serve as evidence of the applicant's authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check and the board's receipt of verification of completion of the Praxis II examination. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

ITEM 5. Amend subrule 20.3(3) as follows:

20.3(3) Background check. Every ~~renewal~~ applicant for renewal or conversion is required to submit a completed application form with the applicant's signature to facilitate a check of the sex offender registry information under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, ~~and the central registry for dependent adult abuse records information maintained under Iowa Code chapter 235B,~~ and the Iowa court information system. The board may assess the applicant a fee no greater than the costs associated with obtaining and evaluating the background check.

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ITEM 6. Amend subrule 22.1(2) as follows:

22.1(2) Requirements. Applicants for the coaching authorization shall have completed the following requirements:

a. and b. No change.

c. ~~Iowa division of criminal investigation background~~ Background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

d. ~~National criminal history background check.~~ Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

ITEM 7. Amend paragraph **22.2(1)“a”** as follows:

a. Requirements. Applicants for the substitute authorization shall meet the following requirements:

(1) to (3) No change.

(4) ~~Iowa division of criminal investigation background~~ Background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

(5) ~~National criminal history background check.~~ Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

ITEM 8. Amend subrule 22.3(4) as follows:

22.3(4) Specific requirements for an initial school business official authorization. Applicants for an initial school business official authorization shall have completed the following requirements:

a. and b. No change.

c. ~~Iowa division of criminal investigation background~~ Background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

d. ~~National criminal history background check.~~ Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

ITEM 9. Amend paragraph **22.5(3)“b”** as follows:

b. ~~Iowa division of criminal investigation background~~ Background check. The applicant must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. The applicant must complete the background check requirements set forth in rule 282—13.1(272).

ITEM 10. Rescind paragraph **22.5(3)“c.”**

ITEM 11. Reletter paragraphs **22.5(3)“d”** to **“g”** as **22.5(3)“c”** to **“f.”**

ITEM 12. Amend subrule 22.5(6) as follows:

22.5(6) Conversion. The preliminary native language teaching authorization may be converted to a native language teaching authorization. The applicant must provide official transcripts verifying the completion of the coursework required in 22.5(3)“e.” “d.”

ITEM 13. Amend subrules 22.7(3) and 22.7(4) as follows:

22.7(3) Application process. Any person interested in the school administration manager authorization shall submit to the board of educational examiners an application which includes a written verification of employment from a school district administrator. Application materials are available from the office of the board of educational examiners, online at <http://www.boee.iowa.gov/>.

A person serving as a school administration manager prior to July 1, 2014, is eligible for the standard school administration manager authorization, subject to the Iowa division of criminal investigation and national criminal history background checks. The person will be assessed the background check fee. The

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~~school administration manager must have completed the school administration manager training and be listed on the Basic Educational Data Survey as a school administration manager by October 31, 2013. The application fee for such persons will be waived if the application is received prior to June 30, 2014.~~

~~22.7(4) Specific requirements for an initial school administration manager authorization. Applicants for an initial school administration manager authorization shall have completed the following requirements:~~

~~a. and b. No change.~~

~~c. Iowa division of criminal investigation background Background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. Applicants must complete the background check requirements set forth in rule 282—13.1(272).~~

~~d.—National criminal history background check. Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.~~

ITEM 14. Amend paragraph **22.8(3)“b”** as follows:

~~b. Iowa division of criminal investigation background Background check. The applicant must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. The applicant must complete the background check requirements set forth in rule 282—13.1(272).~~

ITEM 15. Rescind paragraph **22.8(3)“c.”**

ITEM 16. Reletter paragraphs **22.8(3)“d”** to **“f”** as **22.8(3)“c”** to **“e.”**

ITEM 17. Amend subrule 22.10(1) as follows:

22.10(1) Application process. Any person interested in the activities administration authorization shall submit an application and records of credit to the board of educational examiners for an evaluation of the required courses or contact hours. Application materials are available from the office of the board of educational examiners online at <http://www.boee.iowa.gov>.

~~a. and b. No change.~~

~~c. Iowa division of criminal investigation background Background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant. Applicants must complete the background check requirements set forth in rule 282—13.1(272).~~

~~d.—National criminal history background check. Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.~~

ITEM 18. Adopt the following **new** paragraph **23.1(1)“d”**:

~~d. Complete the background check requirements set forth in rule 282—13.1(272).~~

ITEM 19. Amend rule 282—24.1(272) as follows:

282—24.1(272) Paraeducator certificates. Iowa paraeducator certificates are issued upon application filed on a form provided by the board of educational examiners. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

ITEM 20. Adopt the following **new** paragraph **27.2(1)“e”**:

~~e. Completes the background check requirements set forth in rule 282—13.1(272).~~

[Filed 10/12/15, effective 12/16/15]

[Published 11/11/15]

EDITOR’S NOTE: For replacement pages for IAC, see IAC Supplement 11/11/15.

ARC 2231C**TRANSPORTATION DEPARTMENT[761]****Adopted and Filed**

Pursuant to the authority of Iowa Code section 307.12 and section 307A.2 as amended by 2015 Iowa Acts, House File 635, section 20, the Iowa Department of Transportation, on October 16, 2015, adopted amendments to Chapter 10, “Administrative Rules,” Chapter 11, “Waiver of Rules,” and Chapter 12, “Declaratory Orders,” Iowa Administrative Code.

Notice of Intended Action for these amendments was published in the September 2, 2015, Iowa Administrative Bulletin as **ARC 2117C**.

The amendments to Chapter 10 strike the definition of “written criticisms” since this term was removed from Iowa Code section 17A.7, change “department’s administrative rules coordinator” to “department’s rules administrator” for clarity and consistency, clarify what the Department includes in the Notice of Intended Action, strike rules concerning the procedures on nonsubstantive amendments since the Department no longer uses emergency procedures to make nonsubstantive changes, make technical changes, and correct the implementation sentence.

The amendments to Chapter 11 add “rules administrator” and “Iowa” to the address for clarity and consistency, make changes to expand the retention period of waiver records, and correct the implementation sentence.

The amendments to Chapter 12 change “department’s administrative rules coordinator” to “department’s rules administrator.”

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.

These amendments are identical to those published under Notice of Intended Action.

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

These amendments are intended to implement Iowa Code sections 17A.1 to 17A.9A, 17A.19 and 307.12 and section 307A.2 as amended by 2015 Iowa Acts, House File 635, section 20.

These amendments will become effective December 16, 2015.

Rule-making actions:

ITEM 1. Amend rule 761—10.1(17A) as follows:

761—10.1(17A) General.

~~10.1(1) Rescinded, effective 1/7/87.~~

~~10.1(2) 10.1(1) Definitions.~~ The definitions in Iowa Code section 17A.2 and the definition of “small business” in Iowa Code section 17A.4A are hereby adopted. In addition:

~~“Commission” means the Iowa transportation commission.~~

~~“Department” means the Iowa department of transportation.~~

~~“Director” means the director of transportation or the director’s designee.~~

~~“Written criticisms” means:~~

~~1. Petitions for rule making, objections filed pursuant to Iowa Code subsection 17A.4(4), and written and oral submissions received during rule making pursuant to Iowa Code paragraph 17A.4(1)“b.”~~

~~2. Petitions for waiver of a rule tendered to the department or granted by the department under 761—Chapter 11.~~

~~3. Letters to the director criticizing or recommending changes to a rule.~~

~~10.1(3) 10.1(2) Address.~~ The address of the department’s administrative rules coordinator administrator is: ~~Administrative Rules Coordinator Administrator,~~ Office of Policy and Legislative Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

TRANSPORTATION DEPARTMENT[761](cont'd)

ITEM 2. Amend rule 761—10.2(17A) as follows:

761—10.2(17A) Rule making.

10.2(1) Notice of Intended Action—approval and content. Written authorization to publish proposed rules under Notice of Intended Action in the “Iowa Administrative Bulletin” shall be made by the director. Each commissioner shall be sent a copy of the Notice of Intended Action before its publication in the Iowa Administrative Bulletin. The Notice of Intended Action shall contain:

~~a. Either the complete text of the proposed rules or a summary of the subjects and issues involved. A copy of the complete text of the proposed rules and a brief explanation of the purpose of the proposed rules.~~

b. The specific legal authority for the proposed rules.

~~b. c.~~ The methods that persons and agencies may use to present their views on the proposed rules. In addition to providing for the submission of written comments, the Notice shall afford any interested person or agency the opportunity to make an oral presentation.

~~e. d.~~ Any other information required by statute or rule.

~~d. Each commissioner shall be sent a copy of the Notice of Intended Action before its publication in the Iowa Administrative Bulletin.~~

10.2(2) No change.

10.2(3) Adoption and filing of rules.

a. The director shall adopt proposed rules unless statutes specifically provide for commission adoption. The commission shall approve rules prior to their adoption by the director ~~except as provided in subrule 10.2(5).~~

b. No change.

10.2(4) Regulatory analysis. A request for issuance of a regulatory analysis shall be submitted to the department’s ~~administrative rules coordinator~~ administrator at the address in subrule ~~10.1(3)~~ 10.1(2).

~~10.2(5) Nonsubstantive amendments to rules.~~ In reliance upon Iowa Code subsection 17A.4(2), rule making concerning nonsubstantive amendments shall be exempted from Iowa Code subsection 17A.4(1) and subrules 10.2(1) and 10.2(2). ~~Because nonsubstantive amendments do not alter the meaning or consequence of a rule, it is determined unnecessary and contrary to the public interest to expend resources in publishing a Notice of Intended Action and providing an opportunity for public comment during the rule-making process. Nonsubstantive amendments may be adopted and filed by the director. Nonsubstantive amendments shall include the following:~~

~~a. Correcting the name, address or telephone number of an organizational unit within the department.~~

~~b. Updating references to the Iowa Code or the Iowa Acts to reflect the most current citation.~~

~~c. Correcting spelling, typographical or grammatical errors.~~

~~d. Eliminating references to gender.~~

10.2(6) 10.2(5) Concise statement. If requested in accordance with this subrule, the department shall issue a concise statement of the principal reasons for and against a rule that has been adopted, incorporating therein the reasons for overruling considerations urged against the rule.

a. The request shall:

(1) No change.

(2) Be submitted in writing to the department’s ~~administrative rules coordinator~~ at the address in subrule 10.1(3) administrator.

(3) Be delivered to the ~~coordinator~~ administrator or postmarked no later than the thirtieth calendar day following adoption of the subject rule.

b. A requested concise statement shall be issued either at the time of rule adoption or within 35 days after the department’s ~~administrative rules coordinator~~ administrator receives the request.

10.2(7) 10.2(6) Registration.

a. and b. No change.

c. *Submission and acknowledgment of requests.* Requests for registration under this subrule shall be submitted to the department’s ~~administrative rules coordinator~~ at the address in subrule

TRANSPORTATION DEPARTMENT[761](cont'd)

~~10.1(3) administrator.~~ The receipt of requests for registration shall be promptly acknowledged by the department. The acknowledgment shall either:

(1) and (2) No change.

ITEM 3. Amend rule 761—10.3(17A) as follows:

761—10.3(17A) Petitions for rule making.

10.3(1) The department shall accept and consider, from any person or agency, petitions for rule making when submitted to the department's ~~administrative rules coordinator at the address in subrule 10.1(3) administrator~~ and prepared in conformance with the following:

a. to c. No change.

~~*d.* Rescinded IAB 6/8/94, effective 7/13/94.~~

10.3(2) The date of receipt of a petition is the day it reaches the department's ~~administrative rules coordinator~~ administrator. The ~~coordinator~~ administrator shall promptly notify the petitioner of the date of receipt and the assigned docket number.

10.3(3) and **10.3(4)** No change.

ITEM 4. Amend **761—Chapter 10**, implementation sentence, as follows:

These rules are intended to implement Iowa Code ~~chapter 25B~~ and sections 17A.1 to 17A.9, 17A.19, 307.10 and 307.12 and section 307A.2 as amended by 2015 Iowa Acts, House File 635, section 20.

ITEM 5. Amend subrule 11.5(3) as follows:

11.5(3) *Submission of petition.* A petition for waiver from the requirements of a rule shall be submitted to the Rules Administrator, Office of Policy and Legislative Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

ITEM 6. Amend subrule 11.8(2) as follows:

11.8(2) The office of policy and legislative services shall, at a minimum, retain for five years records relating to waivers granted or denied under this chapter.

ITEM 7. Amend **761—Chapter 11**, implementation sentence, as follows:

These rules are intended to implement Iowa Code ~~sections 17A.7(2) "b" and section~~ section 17A.9A and Executive Order Number 11, dated September 14, 1999.

ITEM 8. Amend subrule 12.2(2) as follows:

12.2(2) The petition must be submitted to the department's ~~administrative rules coordinator~~ administrator at the following address: ~~Administrative Rules Coordinator~~ Administrator, Office of Policy and Legislative Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

ITEM 9. Amend subrule 12.2(6) as follows:

12.2(6) The date of receipt of the petition is the day it reaches the department's ~~administrative rules coordinator~~ administrator. The ~~coordinator~~ administrator shall promptly send an acknowledgment of receipt to the petitioner or, if applicable, petitioner's representative.

[Filed 10/19/15, effective 12/16/15]

[Published 11/11/15]

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ARC 2232C

TRANSPORTATION DEPARTMENT[761]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 307.10 and 312.3C and section 307A.2 as amended by 2015 Iowa Acts, House File 635, section 20, the Iowa Department of Transportation, on October

TRANSPORTATION DEPARTMENT[761](cont'd)

19, 2015, adopted amendments to Chapter 102, "Secondary Road Fund Distribution Committee," Iowa Administrative Code.

Notice of Intended Action for these amendments was published in the September 2, 2015, Iowa Administrative Bulletin as **ARC 2126C**.

The amendments to Chapter 102 make the following changes:

- Remove language regarding the transition phase, as that has been completed. The existing rules include a transition phase to implement formulas for distributing county road funding.
- Amend language to directly include the formulas. The existing rules include distribution formulas by reference.
- Clarify that the executive director of the Iowa County Engineers Association Service Bureau serves as a nonvoting member of the Committee.
- Clarify how meeting notices are distributed to county supervisors.
- Update Iowa Code citations and the chapter's implementation sentence.

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.

These amendments are identical to those published under Notice of Intended Action.

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

These amendments are intended to implement Iowa Code section 312.3C.

These amendments will become effective December 16, 2015.

Rule-making actions:

ITEM 1. Amend rule 761—102.1(312) as follows:

761—102.1(312) Purpose. The purpose of these rules is to adopt the ~~initial~~ formulas to be used for distribution of moneys in the secondary road fund and the farm-to-market road fund and to formalize the process by which the secondary road fund distribution committee will administer its duties.

102.1(1) Iowa Code ~~Supplement~~ section 312.3C creates a secondary road fund distribution committee and requires the committee to be comprised of representatives appointed by the president of the Iowa County Engineers Association, the president of the Iowa State Association of County Supervisors, and the department of transportation.

102.1(2) Iowa Code ~~Supplement~~ section 312.3C requires the secondary road fund distribution committee to:

a. Determine the methodology to be used for distribution of moneys in the secondary road fund and the farm-to-market road fund. ~~The methodology shall be phased in over a five-year period, beginning July 1, 2006.~~

b. No change.

102.1(3) Iowa Code ~~Supplement~~ section 312.3B requires the Iowa County Engineers Association Service Bureau to annually compute secondary road fund and farm-to-market road fund distributions using the methodology determined by the secondary road fund distribution committee.

ITEM 2. Rescind rule 761—102.2(312) and adopt the following new rule in lieu thereof:

761—102.2(312) Formulas.

102.2(1) Definitions. As used in this chapter:

"*Bridges*" means those structures under the jurisdiction of a county secondary roads department which are included in the National Bridge Inventory System.

"*Daily vehicle miles of travel*" means the product of a road segment's length, in miles, multiplied by the daily traffic count thereon, in vehicles per day, reported for that segment by the Iowa department of transportation, based on the most recent counts available.

"*Earth surfaced*" means roads under the jurisdiction of a county secondary roads department which are not surfaced.

TRANSPORTATION DEPARTMENT[761](cont'd)

“*Formula*” means the appropriate secondary road fund distribution formula or farm-to-market road fund distribution formula as defined in subrules 102.2(2) and 102.2(3).

“*Granular surfaced*” means roads under the jurisdiction of a county secondary roads department which have crushed rock, gravel, or oiled earth surfaces.

“*Paved surfaced*” means roads under the jurisdiction of a county secondary roads department with hot mix asphalt, Portland cement concrete, or stabilized base with waterproof surfacing.

“*Rural population*” means the count, taken from the most recently certified decennial federal census, of persons who reside in the unincorporated areas of a county.

102.2(2) *Formula for determining secondary road fund allocation factors.* The Iowa County Engineers Association Service Bureau shall annually compute percentage allocation factors for the allocation of secondary road fund revenues among the counties by calculating and summing the following percentage subtotals for each county:

- a. Thirty percent times the ratio that the total area of each county bears to the total area of the state.
- b. Ten percent times the ratio that the rural population of each county bears to the total rural population of the state.
- c. Twelve and one-half percent times the ratio that the total daily vehicle miles of travel on each county’s secondary roads bears to the total daily vehicle miles of travel on all secondary roads in the state.
- d. One-half percent times the ratio that the earth-surfaced miles of secondary roads of each county bears to the total miles of earth-surfaced secondary roads in the state.
- e. Twenty percent times the ratio that the granular-surfaced miles of secondary roads of each county bears to the total miles of granular-surfaced secondary roads in the state.
- f. Thirteen percent times the ratio that the paved-surfaced miles of secondary roads of each county bears to the total miles of paved-surfaced secondary roads in the state.
- g. Fourteen percent times the ratio that the length, in lineal feet, of secondary road bridges of each county bears to the total length of secondary road bridges in the state.

102.2(3) *Formula for determining farm-to-market road fund allocation factors.* The Iowa County Engineers Association Service Bureau shall annually compute percentage allocation factors for the allocation of farm-to-market road fund revenues among the counties by calculating and summing the following percentage subtotals for each county:

- a. Thirty percent times the ratio that the total area of each county bears to the total area of the state.
- b. Fifteen percent times the ratio that the rural population of each county bears to the total rural population of the state.
- c. Ten percent times the ratio that the total daily vehicle miles of travel on each county’s farm-to-market roads bears to the total daily vehicle miles of travel on all farm-to-market roads in the state.
- d. Nine percent times the ratio that the granular-surfaced miles of farm-to-market roads of each county bears to the total miles of granular-surfaced farm-to-market roads in the state.
- e. Twenty-three percent times the ratio that the paved-surfaced miles of farm-to-market roads of each county bears to the total miles of paved-surfaced farm-to-market roads in the state.
- f. Thirteen percent times the ratio that the length, in lineal feet, of farm-to-market road bridges of each county bears to the total length of farm-to-market road bridges in the state.

ITEM 3. Amend subrule 102.5(1) as follows:

102.5(1) The secondary road fund distribution committee shall be composed of six county engineers, six county supervisors, ~~and~~ two representatives of the department of transportation, and the executive director of the Iowa County Engineers Association Service Bureau.

ITEM 4. Amend subrule 102.5(5) as follows:

102.5(5) All county members shall be voting members. The department of transportation representatives and the executive director of the Iowa County Engineers Association Service Bureau shall be nonvoting members.

TRANSPORTATION DEPARTMENT[761](cont'd)

ITEM 5. Amend rule 761—102.6(312) as follows:

761—102.6(312) Terms of office and rotation of seats.

102.6(1) Committee members shall serve six-year terms; ~~however, shorter terms shall apply to members of the initial committee, as described in subrule 102.6(3) below.~~ Terms of office shall begin on January 1 in the year of appointment and expire on December 31 in the year of expiration. Members may be reappointed to serve consecutive terms.

102.6(2) No change.

102.6(3) ~~The initial committee is the committee in existence on July 1, 2005. The terms of office and rotations of seats for members of the initial committee shall be as shown in the following table:~~

Year	County Engineer Members	County Supervisor Members	Initial Term Length	Initial Term Ending Date
CY 2006	Large county A	Small county A	1 year	12/31/2006
CY 2007	Medium county A	Medium county A	2 years	12/31/2007
CY 2008	Small county A	Large county A	3 years	12/31/2008
CY 2009	Large county B	Small county B	4 years	12/31/2009
CY 2010	Medium county B	Medium county B	5 years	12/31/2010
CY 2011	Small county B	Large county B	6 years	12/31/2011

~~The initial committee shall, by resolution and in accordance with this table, assign initial term ending dates to apply to its members.~~

~~**102.6(4)** **102.6(3)** As initial terms expire, the incumbents may be reappointed or replaced. Each new term shall be for a full six-year period.~~

~~**102.6(5)** **102.6(4)** If a committee member is unable to complete a term of office for any reason, a replacement member of the same class (county engineer or county supervisor) and from the same group (a large, medium or small county) shall be appointed to serve the balance of the term.~~

~~**102.6(6)** **102.6(5)** The committee shall select from its membership a chair and a vice-chair to serve one-year terms. The chair and vice-chair serve at the pleasure of the committee and may be elected to multiple terms as the committee deems appropriate. The vice-chair shall preside at a meeting in the absence of the chair.~~

ITEM 6. Amend subrule 102.7(6) as follows:

102.7(6) In addition to the requirements of Iowa Code chapter 21, the chair shall post meeting agendas on the Iowa County Engineers Association Web site and the Iowa State Association of County Supervisors Web site and shall send copies of agendas to all county engineers and to all county auditors for distribution to supervisors.

ITEM 7. Amend **761—Chapter 102**, implementation sentence, as follows:

These rules are intended to implement Iowa Code ~~Supplement section~~ sections 312.2, 312.3, 312.3B, 312.3C and 312.5.

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[Published 11/11/15]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 11/11/15.

ARC 2238C

VOLUNTEER SERVICE, IOWA COMMISSION ON[817]

Adopted and Filed

Pursuant to the authority of 2015 Iowa Acts, House File 488, section 2, and Iowa Code section 17A.3, the Iowa Commission on Volunteer Service hereby adopts new Chapter 11, "Iowa Reading Corps," Iowa Administrative Code.

The overall goal of the Iowa Reading Corps program is to ensure Iowa Reading Corps members are using evidence-based literacy instruction. Iowa Reading Corps is designed to benefit students from prekindergarten to third grade who are not proficient in reading or who are at risk of becoming not proficient in reading. The Iowa Reading Corps program will provide Iowa Reading Corps AmeriCorps members with the tools needed for literacy instruction to meet goals set by the Commission and the Department of Education.

Notice of Intended Action was published in the August 19, 2015, Iowa Administrative Bulletin as **ARC 2107C**. No public comment was received on these rules. These rules are identical to those published under Notice of Intended Action.

These rules were adopted by the Commission on October 20, 2015.

These rules are intended to implement 2015 Iowa Acts, House File 488, section 2.

These rules shall become effective December 16, 2015.

The following amendment is adopted.

Adopt the following new 817—Chapter 11:

CHAPTER 11
IOWA READING CORPS

817—11.1(15H) Purpose and program description. The purpose of the Iowa reading corps program is to provide Iowa reading corps AmeriCorps members with a data-based, problem-solving model of literacy instruction to use in tutoring students from prekindergarten to third grade who are not proficient in reading or who are at risk of becoming not proficient in reading. The program shall use models of early literacy instruction reviewed and approved by the Iowa department of education pursuant to Iowa Code section 256.9(53) "c." Iowa reading corps grants will give support, on a competitive basis, to AmeriCorps programs in Iowa that utilize AmeriCorps funding awarded by the commission and other funds received in the community programs account established pursuant to 2015 Iowa Acts, House File 488, section 2. The program is established under the authority of the Iowa commission on volunteer service in collaboration with the Iowa department of education pursuant to Iowa Code chapter 15H as amended by 2015 Iowa Acts, House File 488.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.2(15H) Applications. Appropriate forms and applications for grants and eligibility preapproval are available from the commission at www.volunteeriowa.org.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.3(15H) Program eligibility criteria. The commission and department of education will establish criteria consistent with federal regulations to ensure the alignment of the program with the goals outlined in Iowa Code section 256.9(53) "c" and 281—Chapter 62. Any program determined eligible for inclusion as an Iowa reading corps program must ensure that it meets standards outlined by the department of education in 281—Chapter 62, with the exception of existing early literacy-focused and single school district AmeriCorps programs operating in the 2014-2015 school year. These existing programs, upon request to the commission, will be granted conditional eligibility for inclusion for the 2015-2016 school year to provide adequate time for the programs to be evaluated and to make adjustments deemed necessary for the alignment of the program with the goals outlined in 2015 Iowa

VOLUNTEER SERVICE, IOWA COMMISSION ON[817](cont'd)

Acts, House File 488, section 2. Once a program is granted conditional eligibility, the program will be considered preapproved and eligible for the 2016-2017 application. In subsequent years, all applicants must be preapproved by the department of education as eligible to compete for Iowa reading corps grants.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.4(15H) Grant criteria. Beginning with the 2016-2017 program year applications, the commission will establish criteria and funding priorities consistent with federal regulations and the goals of the department of education and the commission. Preapproval of applicant eligibility shall be sought as outlined in 817—11.3(15H). Applicants will be considered either in conjunction with the regular AmeriCorps grant process or, in certain cases, through special competitions outlined and announced by the commission. At a minimum, the criteria will include the following:

1. Goals and objectives of the project;
2. Qualifications of the applicant to manage funds;
3. For new and returning applicants, letters of local support verifying coordination and community cooperation;
4. Total project budget;
5. For previous grantees, evidence of ability to submit timely and accurate reports;
6. Description and time line of planned activities;
7. Description of the applicant organization, including staffing pattern;
8. Documentation of the applicant's ability to provide the required local match;
9. Program performance and evaluation results and outcomes; and
10. Demonstration of the project's alignment with literacy program goals and strategies developed by the department of education, the local school districts served, and the Iowa reading research center.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.5(15H) Designated funds. A percentage of grant funding may be designated by the commission to address specific underserved or high-need geographic areas or schools. In advance of the competition, the commission may also set a minimum amount available for reading corps grants financed with state, federal and private funds, as well as any minimum or maximum funding amounts for individual applicants based on program need and the service territory of the communities described, and past performance of use of funds, if applicable. The commission may also give priority to programs that serve underserved or high-need areas or schools.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.6(15H) Application process for new grants.

11.6(1) Request for application. The commission shall issue a request for applications, which shall include program criteria and application forms for the applicable fiscal year.

11.6(2) Application time frame. The applicant shall submit the completed application to the commission according to the time line identified in the request for application.

11.6(3) Application review process. Applications will be reviewed by a grant review committee, which is composed of members of the commission grant review committee, individuals with expertise in youth programming, and citizens of Iowa. Using the criteria in rule 817—11.4(15H), the committee will review the applications based on the appropriateness and merit of the projects.

11.6(4) Notification. Applicants whose projects have been selected for funding shall be notified by the commission.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.7(15H) Administration of grants.

11.7(1) Contracts. The commission shall prepare contractual agreements for the grants.

a. The contract shall be executed by the executive director of the commission and the duly authorized official of the project.

VOLUNTEER SERVICE, IOWA COMMISSION ON[817](cont'd)

b. The contract shall include due dates and the process for the submission of the progress reports and financial reports.

11.7(2) Reporting. All grant recipients shall submit progress and financial reports to the commission.

11.7(3) Availability of funds. A separate request for applications will be issued only when there are available funds for this program. To the extent allowable by federal regulations, Iowa reading corps will always be an acceptable program model for annual AmeriCorps grants and will be listed in the annual AmeriCorps program request for applications.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

817—11.8(15H) Reversion of funds. Grant funds not expended by the project closeout date shall revert to the commission and the community programs account established pursuant to 2015 Iowa Acts, House File 488, section 2.

This rule is intended to implement 2015 Iowa Acts, House File 488, section 2.

[Filed 10/21/15, effective 12/16/15]

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