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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay or suspension imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515)281-3355 or (515)242-6873

Administrative Services Department[11]

Replace Chapter 41
Replace Chapter 64

Attorney General[61]

Replace Analysis
Insert Chapter 38

Economic Development Authority[261]

Replace Analysis
Replace Chapter 23
Replace Chapter 115

Educational Examiners Board[282]

Replace Chapter 24

Human Services Department[441]

Replace Analysis
Replace Chapter 2
Replace Chapter 25
Replace Chapter 34
Replace Chapter 78
Replace Chapter 81
Remove Chapter 101 and Reserved Chapter 102
Insert Reserved Chapters 101 and 102

Public Safety Department[661]

Replace Analysis
Replace Chapter 35
Replace Chapter 80

Revenue Department[701]

Replace Analysis
Replace Chapter 42

Transportation Department[761]

Replace Analysis
Replace Chapter 400

Replace Chapter 405
Replace Chapter 411
Replace Chapter 450

CHAPTER 41
AUDITING CLAIMS

[Prior to 12/17/86, see Comptroller, State[270] Ch 1]

[Prior to 5/12/04, see 701—Ch 201]

All vouchers and claims required by law to be audited by the department of administrative services, state accounting enterprise, should conform to the following rules.

11—41.1(8A) General provisions.

41.1(1) *Submission of claims and approval.* All claims shall be typewritten, or written in ink, and be itemized and certified by the claimant.

EXCEPTION: The claimant's certification is not needed when the original invoice is attached to the claim. The original invoice shall indicate in detail the items of service, expense, thing furnished, or contract upon which payment is sought.

Approval of the claim shall be certified thereon by the head of the state agency, or the deputy, or the chair of the board or commission or its executive officer, or by a person delegated by the head of the state agency to fulfill this responsibility. A list of authorized signators shall be provided to the department of administrative services, state accounting enterprise.

All travel claims submitted shall be the actual expense incurred (not exceeding maximum limitations) by the claimant, and shall not include expenses paid for other individuals, or for the purchase of miscellaneous items which are not needed in the performance of official duties while traveling. All travel vouchers shall contain the vendor/customer code of the employee or other individual identification (with prior written approval by the department of administrative services, state accounting enterprise).

All claims shall show in the space provided the Iowa Code reference for the appropriation or fund from which the claim is payable.

When an original invoice is submitted by a vendor, rather than the claimant signing the voucher, the vendor shall provide the state agency with an original invoice that the vendor would use in the normal conduct of its business. A state agency shall not impose additional or different requirements on submission of invoices than those contained in these rules unless the department of administrative services, state accounting enterprise, exempts the agency from these invoice requirements upon a finding that compliance would result in poor accounting or management practices.

41.1(2) *Interest on claims.* For any claim received for services, supplies, materials or a contract which is payable from the state treasury that remains unpaid after 60 days following the receipt of the claim or the satisfactory delivery, furnishing or performance of the services, supplies, materials or contract, whichever date is later, the state shall pay interest at the rate of 1 percent per month on the unpaid amount of the claim. Agencies may enter into written contracts for goods and services on payment terms of less than 60 days if the state may obtain a financial benefit or incentive which would not otherwise be available from the vendor. All agencies entering into written contracts for goods and services on payment terms of less than 60 days shall maintain written documentation demonstrating that the agency obtained a financial benefit or incentive which would not otherwise have been available from the vendor. This subrule does not apply to claims against the state under Iowa Code chapters 25 and 669 or the claims paid by federal funds. The interest shall be charged to the appropriation or fund to which the claim is certified.

41.1(3) *Availability of rules.* All state agencies are required to mail the number of copies of the proposed rule as requested to the state office of a trade or occupational association which has registered its name and address with the agency. The trade or occupational association shall reimburse the agency for the actual cost incurred in providing the copies of the proposed rule.

41.1(4) *Property claims and real estate claims.* Claims for personal property sold, the acquisition of real estate, or services rendered to the state must have the original invoices or other documentation attached whenever possible to do so.

41.1(5) *Form for travel claim.* All travel claims are to be on a travel voucher or on a form approved (in writing) by the department of administrative services, state accounting enterprise.

41.1(6) *Intradepartmental rules on claims.* All intradepartmental rules pertaining to the auditing of claims internally shall be subject to the review and approval (in writing) of the department of administrative services, state accounting enterprise.

This rule is intended to implement Iowa Code sections 8A.514 and 17A.4.
[ARC 3002C, IAB 3/29/17, effective 5/3/17; ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—41.2(8A) Official travel.

41.2(1) *Personal funds to be supplied.* All employees shall provide themselves with sufficient funds for all current expenses. See subrules 41.2(3) and 41.2(4) regarding travel advances.

41.2(2) *Reimbursable expenses and travel allowances.* The reimbursement allowed shall be limited to an allowance for subsistence and transportation, and other actual and necessary travel expenses incurred by a traveler in the performance of official duties subject to applicable limitations. All travel reimbursements shall be made on the basis of the usually traveled route.

41.2(3) *Travel advance.* State employees who are required to travel out of state may apply for a travel advance if the anticipated out-of-pocket expenses are in excess of \$200. An advance may not exceed 80 percent of the anticipated expenses. In addition, employees shall comply with the conditions set forth below:

a. The travel advance shall be deducted from the expense voucher submitted by the employee upon completion of the trip.

b. If for any reason an employee does not make the anticipated trip, the travel advance shall be immediately returned to the state.

c. The employee shall give the department of administrative services, state accounting enterprise, authority to recover funds owed the state (through payroll deduction) which have not been repaid within 30 days of completion of the trip.

d. The department of administrative services, state accounting enterprise, reserves the right to refuse advances when funds are currently owed the state or when there have been prior abuses.

41.2(4) *Permanent in-state travel advance.* State employees who are not covered by collective bargaining agreements negotiated under the provisions of Iowa Code chapter 20 may be eligible for a permanent in-state travel advance if they meet and agree to the following conditions:

a. Employees whose in-state travel expense reimbursements average between \$100 and \$150 per month for the preceding 12 months shall receive upon written request a permanent travel allowance of \$100.

b. Employees whose in-state travel expense reimbursements average over \$150 per month for the preceding 12 months shall receive upon written request a permanent travel allowance of \$150.

c. The department of administrative services, state accounting enterprise, shall have authority to deduct the permanent travel advance from the employee's last paychecks upon separation from state service.

d. The department of administrative services, state accounting enterprise, and employing agency reserve the right to review the employee's monthly travel expenses and should the employee fail to meet the above requirements, or become ineligible due to a change in duties or job assignment, the advance will be withdrawn (through payroll deduction) following proper notification.

41.2(5) *Official domicile defined.*

a. Office employee. The official domicile of an officer or employee assigned to an office is the city, town or metropolitan area (as established by the department of administrative services, state accounting enterprise) within which such office is located. Transportation costs between the employee's residence and office, and subsistence within the limits of an employee's official domicile are not reimbursable.

b. Field employees. The official domicile of field employees shall be designated by the administrative head of the state agency. Subsistence within the limits of an employee's official domicile shall not be allowed. No transportation costs will be allowed between the employee's place of residence and office.

c. Nonreimbursable travel. When additional expense is incurred by reason of an employee residing in a city or town other than the employee's official domicile, the additional expense is otherwise caused by an employee's choice of residence, and is not reimbursable.

11—41.3(8A) Temporary duty assignment.

41.3(1) *Subsistence while on temporary duty assignment.* When an employee is on temporary duty assignment, subsistence may be allowed for each day (including Saturdays, Sundays and holidays) from the time of departure from the employee's official domicile until the employee's return to the previous official domicile or a newly assigned domicile.

41.3(2) *Weekends.* When authorized by the administrative head of the agency or the designated representative, an employee who is on temporary duty status will be reimbursed for expenses involved while returning home for the weekend provided the amount, including transportation, does not exceed the amount that would have been allowable had the claimant remained at the temporary duty station.

11—41.4(8A) Authorization for travel.

41.4(1) *Approval by administrative head of the agency.* All official travel shall be authorized by the administrative head of the agency or the designated representative, prior to the travel whenever possible.

41.4(2) *Out of state.* Official travel out of the state for any executive branch employee must receive prior electronic authorization on the Travel Department Authorization form from the administrative head of the agency or the designated representative.

41.4(3) *Requests for out-of-state travel.* All requests for out-of-state travel shall be on a form approved by the administrative head of the agency and shall include information required by Iowa Code section 8A.512A.

41.4(4) *Most economical or advantageous mode of travel.* Reimbursement for transportation approved by the administrative head of the agency or the designated representative shall be for the most economical or advantageous mode and by the usually traveled route.

[ARC 2267C, IAB 11/25/15, effective 12/30/15; ARC 6236C, IAB 3/9/22, effective 4/13/22]

11—41.5(8A) Mode of transportation.

41.5(1) *Airline travel accommodations.* When the administrative head of the agency or the designated representative determines that airline travel is the most economical or advantageous to the state, the use of airline travel may be authorized. The most economical mode of airline travel is considered to be coach or economy class, if available.

41.5(2) *Train travel.* In cases where train travel is utilized, the most economical mode shall be considered coach fare, if available.

41.5(3) *Purchase of tickets.*

a. All state agencies covered by the statewide travel agency contracts may purchase airline tickets through a travel agency under contract. Agencies shall develop internal policies so that agencies purchase or direct their employees to purchase tickets from the source determined by the agency to be the best value.

b. For all other tickets purchased, it shall be the employee's responsibility to purchase the ticket for whatever mode of transportation that is determined to be the most economical. Reimbursement will be made by attaching a receipt to the employee travel voucher. Refunds received on any unused portion of the ticket shall be shown and deducted from the original ticket.

41.5(4) *Use of privately owned vehicle.* Authorized use of a privately owned vehicle for travel on official state business will be subject to rule 11—103.4(8A).

a. In state. Where use of a privately owned vehicle is authorized by rule 11—103.4(8A), reimbursement shall be on a mileage basis at a rate established by the director pursuant to Iowa Code section 8A.363. Reimbursement for travel at the official domicile will be reimbursed at a rate (established by the director pursuant to Iowa Code section 8A.363) per mile if the purpose of the travel is official business. The per-mile reimbursement includes all costs incurred in connection with the operation of the vehicle.

b. Out of state. If the traveler desires to use a personally owned vehicle instead of common carrier and it is authorized by the administrative head of the agency or the designated representative, the cost of mileage (not to exceed airfare) to the destination's nearest air terminal, plus expenses incurred to final destination and subsistence allowance en route will be allowed. Out-of-state subsistence allowance will be allowed only for the number of meals and nights lodging which would have been necessary had the traveler used the available public transportation to destination instead of a private vehicle. Taxi or mileage expenses will be allowed at the destination if the expenses are incurred while the traveler is on official business.

If two or more travelers on official business travel in one privately owned vehicle instead of common carrier, the use of one vehicle may be authorized on a mileage basis not to exceed the statutory limit per mile.

41.5(5) Mileage while on temporary duty assignment. In general, mileage for use of privately owned vehicles may be allowed for travel within the area of temporary duty, if approved by the administrative head of the agency, provided a state-owned vehicle is not available. When a privately owned vehicle is authorized in the transaction of official business within the area or in the vicinity of the city to which the traveler is assigned or directed, the traveler shall show on the travel claim the number of miles of vicinity travel for each.

41.5(6) Assignment of more than one employee to a vehicle. In authorizing the use of privately owned or state-owned vehicles, the administrative head of the agency or the designated representative shall, whenever possible, assign more than one employee to the use of one vehicle.

41.5(7) Verification of mileage. The travel shall be by the usually traveled route. Mileage shall be based on mileage published by the American Automobile Association, when available. Any variation from the published mileage should be documented in writing.

41.5(8) Use of buses, street cars, limousines and rental cars. When buses, street cars, limousines, or rental cars are used for official travel within the official station or city to which a traveler is directed, the traveler shall show the cost of the fares in the "miscellaneous" column of the travel voucher.

41.5(9) Abode and point of duty in interstate travel. Insofar as official interstate travel is concerned, the employee's hotel may be considered a point of official duty.

41.5(10) Taxicabs. Taxicab charges shall be allowed only from regular domicile or place of business to station or other terminal; from station or terminal at origin of destination of trip to hotel or domicile or place of business; or between bus, rail or plane stations or terminals or other points of official duty.

41.5(11) Home-travel from and to. Actual taxi or common carrier fares shall be allowed for transportation directly from home of traveler to railroad, bus or airport terminals at the beginning of official travel status and for transportation directly from railroad, bus or airport terminals to home of traveler at conclusion of official travel status. The maximum reimbursement will be the current cost of taxi fare from the capitol to the Des Moines airport.

41.5(12) Rental or charter of special conveyances. The rental or charter of aircraft, automobiles, boats, buses, or other special conveyances shall be held to a minimum but may be authorized in those cases when no public or ordinary means of transportation is available, or when such public or ordinary means of transportation cannot be used advantageously in the best interest of the state. Specific justification shall accompany the voucher in each instance where the use of special conveyance is authorized and shall include information such as the location where special conveyance commenced, and the points visited. The department of administrative services, state accounting enterprise, may require a comparison of costs between public or ordinary means of transportation compared to the cost of special conveyance.

[ARC 2267C, IAB 11/25/15, effective 12/30/15; ARC 4053C, IAB 10/10/18, effective 11/14/18; ARC 6236C, IAB 3/9/22, effective 4/13/22]

11—41.6(8A) Subsistence allowance.

41.6(1) The phrase "subsistence allowance." The phrase "subsistence allowance" used herein shall be construed to include all charges (including applicable taxes) for meals and lodging (single rate only). Charges for radios, television, and similar appliances are not reimbursable.

41.6(2) *Subsistence allowances for in-state travel—monetary and time limitations.* Officers and employees shall be allowed overnight lodging and meal expense when required to travel outside of the city of their official domicile. The amounts shall not exceed the limits established in the department of administrative services, state accounting enterprise, procedure manual.

a. Rescinded, effective February 19, 1986.

b. Rescinded, effective February 19, 1986.

41.6(3) *Subsistence allowances for out-of-state travel—monetary and time limitations.*

a. Lodging and meal expenses are not limited outside the state but the incurred expenditures are to be reasonable. Receipts for lodging are to accompany the claim and show the dates, room number, occupants, and amount per night. Lodging will be limited to the night preceding and the night of the ending date of the convention or meeting. Elected officials are not required to furnish receipts.

b. Meals will be limited to lunch and dinner the day preceding and breakfast and lunch the day after the meeting.

11—41.7(8A) Miscellaneous expense.

41.7(1) *Definition.* Miscellaneous expenses are those deemed necessary in the conduct of official business of the state which are not included in the categories of subsistence, mileage, and state-owned vehicle operation. All miscellaneous expenses shall be claimed under the column heading “miscellaneous expense” on the travel claim and be supported by sufficient documentation.

41.7(2) *Receipts.* A receipt for, or explanation of, each and every transaction involving miscellaneous expenditures shall be provided.

41.7(3) *Baggage.* Charges for baggage in excess of the weight or of the size carried free by transportation companies shall be allowed if the baggage is used for official business. Charges for the storage of baggage may also be allowed if it is shown that such storage was on account of official business. Specific justification must be submitted with the claim voucher.

41.7(4) *Telephone and telegraph messages.* Expenses for official telephone and telegraph messages which must be paid for by the traveler shall be allowed. Toll and local calls and telegrams should be supported and attached to the travel claim showing date, city or town called or telegraphed, name of person or firm called or to where telegram was sent and amount of each call or telegram.

41.7(5) *Stenographic or typewriting services.* Charges for official stenographic or typewriting services shall be allowed on official travel.

41.7(6) *Purchase of supplies.* The purchase of stationery and all other similar supplies shall be allowed in emergencies warranting their use for handling of official business while on official travel, and shall be submitted and certified on a travel voucher (or other approved form) with the proper receipts attached.

41.7(7) *Parking.* Parking will be allowed for state and private cars at an airport during the employee’s flight.

41.7(8) *Registration fees.* The payment of registration fees which are required for participation in meetings shall be allowed. Registration fees shall be supported by the official receipt of the conference or convention subject to the following limitations:

a. Expenditures for payment of registration fees for the purpose of obtaining the privileges of membership or other personal benefits from an organization are not reimbursable. Memberships in organizations must be in the name of the state agency and have approval of the director of the department or designated representative requesting the membership and shall be published to the Iowa transparency Internet site established by Iowa Code section 8G.4.

b. Registration fees paid by the traveler will be claimed for reimbursement as a miscellaneous nonsubsistence expense and a receipt must be attached to the claim.

c. Reimbursement of registration fees, at the official domicile, may require prior written approval of the department of administrative services, state accounting enterprise.

[ARC 0636C, IAB 3/6/13, effective 4/10/13; ARC 6236C, IAB 3/9/22, effective 4/13/22]

11—41.8(8A) State-owned vehicle. Any expense other than parking should not be claimed on the expense voucher but should be reimbursed through procedures established by fleet services.

[ARC 4053C, IAB 10/10/18, effective 11/14/18]

Rules 11—41.2(8A) to 11—41.8(8A) are intended to implement Iowa Code sections 8A.506 to 8A.519.

[Filed 2/16/66; amended 2/9/71, 12/12/73, 7/5/74, 12/23/74]

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[Filed ARC 2267C (Notice ARC 2145C, IAB 9/16/15), IAB 11/25/15, effective 12/30/15]

[Filed ARC 3002C (Notice ARC 2790C, IAB 10/26/16), IAB 3/29/17, effective 5/3/17]

[Filed ARC 4053C (Notice ARC 3937C, IAB 8/15/18), IAB 10/10/18, effective 11/14/18]

[Filed ARC 6236C (Notice ARC 5981C, IAB 10/20/21), IAB 3/9/22, effective 4/13/22]

CHAPTER 64

BENEFITS

[Prior to 8/15/86; See Deferred Compensation Program, 270—Ch 4]

[Prior to 1/7/04, see 581—Ch 15]

11—64.1(8A) Health benefits. The director is authorized by the executive council of Iowa to administer health benefit programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A. The executive council of Iowa shall determine the amount of the state's contribution toward each individual employee's premium cost and shall authorize the remaining premium cost to be deducted from the employee's pay. The state's contribution for each contract-covered employee shall be as provided for in applicable collective bargaining agreements negotiated in accordance with Iowa Code chapter 20. [ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—64.2(8A) Dental insurance. The director is authorized by the executive council of Iowa to administer dental insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.3(8A) Life insurance. The director is authorized by the executive council of Iowa to administer life insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A, except for employees of the board of regents.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.4(8A) Long-term disability insurance. The director is authorized by the executive council of Iowa to administer long-term disability insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A, except for employees of the board of regents.

Employees who receive loss of time benefits under the state workers' compensation program shall have those benefits, except for benefits designated as medical costs pursuant to Iowa Code section 85.27 and that portion of benefits paid as attorneys' fees approved pursuant to Iowa Code section 86.39, deducted from any state long-term disability benefits received where the workers' compensation injury or illness was a substantial contributing factor to the award of long-term disability benefits. Disability benefit payments will be further reduced by primary and family social security payments as determined at the time social security disability payments commence, railroad retirement disability income, and any other state-sponsored sickness or disability benefits payable.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.5(8A) Health benefit appeals. A member who disagrees with a group health benefit company's decision on the application of group contract benefits may:

1. File a written appeal with the respective company as defined in the group contract, or
2. File a written appeal with the commissioner of insurance at the department of commerce.

11—64.6(8A) Deferred compensation.

64.6(1) Definitions. The following definitions shall apply when used in this rule:

"Account" means any fixed annuity contract, variable annuity contract, life insurance contract, documents evidencing mutual funds, variable or guaranteed investments, or combination thereof provided for in the plan.

"Beneficiary" means the person or estate entitled to receive benefits under the plan following the death of the participant.

"Director" means the director of the Iowa department of administrative services.

"Employee" means a nontemporary (permanent full-time or permanent part-time) employee of the employer, including full-time elected officials and members of the general assembly, except employees of the board of regents. For the purposes of enrollment, elected officials-elect and members-elect of the general assembly shall be considered employees. Persons in a joint employee relationship with the employer shall not be considered employees eligible to participate in the plan.

“*Employer*” means the state of Iowa and any other governmental employer that participates in the plan. Effective July 1, 2003, “employer” shall also include any governmental entity located within the state of Iowa that enters into an agreement to allow its employees to participate in the plan.

“*Fiduciary*” means a person or company that manages money or property for another and that must exercise the standard of care imposed by law or contract. For the purpose of these rules, “fiduciary” means the trustee, the plan administrator, investment providers, and the persons they designate to carry out or help carry out their duties or responsibilities as fiduciaries under the plan.

“*Governing body*” means the executive council of the state of Iowa.

“*Group*” means one or more employees.

“*Investment provider*” means a company authorized under this rule to issue an account or administer the records of such an account or accounts under the deferred compensation plan authorized by Iowa Code sections 8A.402 and 509A.12.

“*Normal retirement age*” means 65 years of age, unless an employee declares a different age pursuant to the plan’s catch-up provision. The age cannot be earlier than a year in which the employee is eligible to receive retirement benefits without an age reduction penalty from the employer-sponsored retirement plan.

“*Participating employee*” or “*participant*” means any employee or former employee of the employer who is currently deferring or who has previously deferred compensation under the plan and who retains the right to benefits under the plan.

“*Plan*” means the state of Iowa employee contribution plan for deferred compensation as authorized by Internal Revenue Code Section 457 and Iowa Code sections 8A.434 and 509A.12.

“*Plan administrator*” means the designee of the director who is authorized to administer the plan.

“*Plan year*” means a calendar year.

“*Retirement investors’ club*” means the voluntary retirement savings program for employees designed to increase personal long-term savings. The program contains three plans, the 457 employee contributions plan, the 401(a) employer contribution plan, and the 403(b) tax-sheltered annuity plan.

“*Trust*” means the Iowa state employee deferred compensation trust fund created in the state treasury and under the control of the department.

“*Trustee*” means the director of the Iowa department of administrative services.

64.6(2) Plan administration.

a. Director’s authorization. The director is authorized by the governing body to administer a deferred compensation program for eligible employees and to enter into contracts and service agreements with deferred compensation investment providers for the benefit of eligible employees and on behalf of the state of Iowa and other eligible employers. This rule shall govern all investment options and participant activity for the funds placed in the program.

b. Plan modification. The trustee may at any time amend, modify, or terminate the plan without the consent of the participant (or any beneficiary thereof). The plan administrator shall provide to participating employees and investment providers sufficient notice of all amendments to the plan. No amendment shall deprive participants of any of the benefits to which they are entitled under the plan with respect to deferred amounts credited to their accounts before the effective date of the amendment. If the plan is curtailed or terminated, or the acceptance of additional deferred amounts is suspended permanently, the plan administrator shall nonetheless be responsible for the supervision of the payment of benefits resulting from amounts deferred before the amendment, modification, or termination. Payment of benefits will be deferred until the participant would otherwise have been entitled to a distribution pursuant to the provisions of the plan.

c. Location of account documentation. The investment providers shall send the original annuity policies, contracts or account forms to the plan administrator. Failure to do so may result in termination of an investment provider’s contract or service agreement. The plan administrator shall keep all such original documents. Participating employees may review their own documentation during normal work hours at the department, but may not under any circumstances remove the documentation from the premises.

d. Not an employment contract. Participation in this plan by an employee shall not be construed to give a contract of employment to the participant or to alter or amend an existing employment contract of the participant, nor shall participation in this plan be construed as affording to the participant any representation or guarantee regarding the participant's continued employment.

e. Tax relief not guaranteed. The employer, trustee, and the investment providers do not represent or guarantee that any particular federal or state of Iowa income, payroll, personal property or other tax consequences will result because of the participant's participation in the plan. The participant is obligated to consult with the participant's own tax representative regarding all questions of federal or state of Iowa income, payroll, personal property or other tax consequences arising from participation in the plan.

f. Investment agents. The investment providers shall, subject to the trustee's consent, have the power to appoint agents to act for the investment providers in the administration of accounts according to the terms, conditions, and provisions of their contracts or service agreements with the plan. Investment providers are responsible for the conduct of their agents, including their adherence to the plan document and administrative rules. The plan administrator may require an investment provider to remove the authority of any agent to provide services to the plan or plan participants when cause has been shown that the agent has violated these rules or state or federal law or regulation related to the governance of the plan or agent conduct.

g. Plan expenses. Expenses incurred by the plan administrator while administering the plan, including fees and expenses approved by the plan trustee for investment advisory, custodial, record-keeping, and other plan administration and communication services, and any other reasonable and necessary expenses or charges allocable to the plan that have been incurred for the exclusive benefit of plan participants and that have been approved by the plan trustee may be charged to the short-term interest that has accrued in the deferred compensation trust fund created by Iowa Code section 8A.434 prior to the allocation of funds to a participant's chosen investment provider. Such expenses may also be funded from fees assessed to eligible employers who choose to offer the plan to their employees.

h. Time periods. As necessary or desirable to facilitate the proper administration of the plan and consistent with the requirements of Section 457 of the Internal Revenue Code (IRC), the plan administrator may modify the time periods during which a participating employee or beneficiary is required to make any election under the plan, and the time periods for processing these elections by the plan administrator, including the making or amending of a deferral agreement, the making or amending of investment provider selections, the election of distribution commencement dates or distribution methods.

i. Supplementary information and procedures. Any explanatory brochures, pamphlets, or notices distributed by the plan shall be distributed for information purposes only and shall not override any provision of the plan or give any person any claim or right not provided for under the plan. In the event any form or other document used in administering the plan, including but not limited to enrollment forms and marketing materials, conflicts with the terms of the plan, the terms of the plan shall prevail.

j. Binding plan. The plan, and any properly adopted amendments, shall be binding on the parties and their respective heirs, administrators, trustees, successors and assignees and on all beneficiaries of the participant.

64.6(3) Rights of participating employees.

a. Exclusive benefit. The trustee shall hold the assets and income of the plan for the exclusive benefit of the participating employee or the participating employee's beneficiary.

b. Creditors. The accounts of a participating employee under the plan shall not be subject to creditors of the participating employee or the participant's beneficiary and shall be exempt from execution, attachment, prior assignment, or any other judicial relief, or order for the benefit of creditors or other third persons.

c. Designation of beneficiary. Upon enrollment, a participating employee must designate a beneficiary or beneficiaries. An employee who has an open account with an investment provider that is no longer able to open new accounts may change the employee's designated beneficiary or beneficiaries at any time thereafter by providing the plan administrator with written notice of the change on the form prescribed by the plan administrator. An employee who has an open account with an investment

provider that is able to open new accounts may change the employee's designated beneficiary or beneficiaries at any time thereafter by completing the investment provider's beneficiary change form.

d. Assignment. Neither a participating employee, nor the participating employee's beneficiary, nor any other designee shall have the right to commute, sell, assign, transfer, borrow, alienate, use as collateral or otherwise convey the right to receive any payments.

64.6(4) Trust provisions.

a. Investment options. The trustee shall adopt various investment options for the investment of deferred amounts by participating employees or their beneficiaries and shall monitor and evaluate the appropriateness of the investment options offered by the plan.

b. Designation of fiduciaries. The trustee, the plan administrator, and the persons they designate to carry out or help carry out their duties or responsibilities are fiduciaries under the plan. Each fiduciary has only those duties or responsibilities specifically assigned to fiduciaries under the plan, contractual relationship, trust, or as delegated to fiduciaries by another fiduciary. Each fiduciary may assume that any direction, information, or action of another fiduciary is proper and need not inquire into the propriety of any such action, direction, or information. No fiduciary will be responsible for the malfeasance, misfeasance, or nonfeasance of any other fiduciary, except where the fiduciary participated in such conduct, or knew or should have known of such conduct in the discharge of the fiduciary's duties under the plan and did not take reasonable steps to compel the cofiduciary to redress the wrong.

c. Fiduciary standards.

(1) All fiduciaries shall discharge their duties with respect to the plan and trust solely in the interest of the participating employees and their beneficiaries and in accordance with Iowa Code section 633.123. Such duties shall be discharged for the exclusive purpose of providing benefits to the participating employees and beneficiaries and, if determined applicable, defraying expenses of the plan.

(2) The investment providers shall discharge their duties with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and as defined by applicable Iowa law.

d. Trustee powers and duties. The trustee may exercise all rights or privileges granted by the provisions of the plan and trust and may agree to any alteration, modification or amendment of the plan. The trustee may take any action respecting the plan or the benefits provided under the plan that the trustee deems necessary or advisable. Persons dealing with the trustee shall not be required to inquire into the authority of the trustee with regard to any dealing in connection with the plan. The trustee may employ persons, including attorneys, auditors, investment advisors or agents, even if they are associated with the trustee, to advise or assist, and may act without independent investigation upon their recommendations. Instead of acting personally, the trustee may employ one or more agents to perform any act of administration, whether or not discretionary.

e. Trust exemption. This trust is intended to be exempt from taxation under IRC Section 501(a) and is intended to comply with IRC Section 457(g). The trustee shall be empowered to submit or designate appropriate agents to submit the plan and trust to the IRS for a determination of the eligibility of the plan under IRC Section 457, and the exempt status of the trust under IRC Section 501(a), if the trustee concludes that such a determination is desirable.

f. Held in trust. Notwithstanding any contrary provision of the plan, in accordance with IRC Section 457(g), all amounts of compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in trust for the exclusive benefit of participants and beneficiaries under the plan. Any trust under the plan shall be established pursuant to a written agreement that constitutes a valid trust under the law of the state of Iowa. All plan assets shall be held under one or more of the following methods:

(1) Compensation deferred under the plan shall be transferred to a trust established under the plan within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, compensation deferred under the plan shall be transferred to a trust established under the plan not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

(2) Notwithstanding any contrary provision of the plan, including any annuity contract issued under the plan, in accordance with IRC Section 457(g), compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in one or more annuity contracts, as defined in IRC Section 401(g), issued by an insurance company qualified to do business in the state where the contract was issued, for the exclusive benefit of participants and beneficiaries under the plan or held in a custodial account as described in subparagraph (3) below. For this purpose, the term “annuity contract” does not include a life, health or accident, property, casualty, or liability insurance contract. Amounts of compensation deferred under the plan shall be transferred to an annuity contract described in IRC Section 401(f) within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, amounts of compensation deferred under the plan shall be transferred to a contract described in IRC Section 401(f) not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

(3) Notwithstanding any contrary provision of the plan, in accordance with IRC Section 457(g), compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in one or more custodial accounts for the exclusive benefit of participants and beneficiaries under the plan or held in an annuity contract as described in subparagraph (2) above. For purposes of this subparagraph, the custodian of any custodial account created pursuant to the plan must be a bank, as described in IRC Section 408(n), or a person who meets the nonbank trustee requirements of Treasury Regulations Section 1.408-2(e)(2) to (6) relating to the use of nonbank trustees.

Amounts of compensation deferred under the plan shall be transferred to a custodial account described in IRC Section 401(f) within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, amounts of compensation deferred under the plan shall be transferred to a custodial account described in IRC Section 401(f) not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

64.6(5) *Absolute safeguards of the employer, trustee, their employees, and agents.*

a. Questions of fact. The trustee and the plan administrator are authorized to resolve any questions of fact necessary to decide the participating employee’s rights under the plan. An appeal of a decision of the plan administrator shall be made to the trustee, or the trustee’s designee, who shall render a final decision on behalf of the plan.

b. Plan construction. The trustee and the plan administrator are authorized to construe the plan and to resolve any ambiguity in the plan and to apply reasonable and fair procedures for the administration of the plan. An appeal of a decision of the plan administrator shall be made to the trustee, or the trustee’s designee, within 30 days of the plan administrator’s decision. The trustee, or the trustee’s designee, shall render a final decision on behalf of the plan.

c. No liability for loss. The participating employee specifically agrees that the employer, the plan, the trustee, the plan administrator, or any other employee or agent of the employer shall not be liable for any loss sustained by the participating employee or the participating employee’s beneficiary for the nonperformance of duties, negligence, or any other misconduct of the above-named persons except that this paragraph shall not excuse malicious or wanton misconduct.

d. Payments suspended. The trustee, plan administrator, investment providers, their employees and agents, if in doubt concerning the correctness of their actions in making a payment of a benefit, may suspend the payment until satisfied as to the correctness of the payment or the identity of the person to receive the payment, or until the filing of an administrative appeal under Iowa Code chapter 17A, and thereafter in any state court of competent jurisdiction, a suit in such form as they consider appropriate for a legal determination of the benefits to be paid and the persons to receive them.

e. Court costs. The employer, the plan, the trustee, the plan administrator, their employees and agents are hereby held harmless from all court costs and all claims for the attorneys’ fees arising from

any action brought by the participating employee, or any beneficiary thereof, under the plan or to enforce their rights under the plan, including any amendments of the plan.

64.6(6) Eligibility. Except employees of the board of regents, any nontemporary executive, judicial or legislative branch employee, or employee of a governmental employer that enters into an agreement to join the plan, who is regularly scheduled for 20 or more hours of work per week or who has a fixed annual salary is eligible to defer compensation under this rule. An elected official-elect and elected members-elect of the general assembly are also eligible provided that deductions meet the requirements set forth in the plan. Final determination on eligibility shall rest with the plan administrator.

64.6(7) Communications.

a. Forms. All enrollments, elections, designations, applications and other communications by or from an employee, participant, beneficiary, or legal representative of any such person regarding that person's rights under the plan shall be made in the form and manner established by the plan administrator and shall be deemed to have been made and delivered only upon actual receipt by the person designated to receive such communication. The employer or the plan shall not be required to give effect to any such communication that is not made on the prescribed form and in the prescribed manner and that does not contain all information called for on the prescribed form.

b. Notices mailed. All notices, statements, reports, and other communications from the plan to any employee, participant, beneficiary, or legal representative of any such person shall be deemed to have been duly given when delivered to, or when mailed by first-class mail to, such person at that person's last mailing address appearing on the plan records.

64.6(8) Disposition of funds while employed.

a. Unforeseeable emergency. A participating employee may request that the plan administrator allow the withdrawal of some or all of the funds held in the participating employee's account based on an unforeseeable emergency. Forms must be completed and returned to the plan administrator for review in order to consider a withdrawal request. The plan administrator shall determine whether the participating employee's request meets the definition of an unforeseeable emergency as provided for in federal regulations. In addition to being extraordinary and unforeseeable, an unforeseeable emergency must not be reimbursable:

- (1) By insurance or otherwise;
- (2) By liquidation of the participating employee's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship; or
- (3) By cessation of deferrals under the plan.

Upon the plan administrator's approval of an unforeseeable emergency distribution, the participating employee will be required to stop current deferrals for a period of no less than six months.

A participating employee who disagrees with the initial denial of a request to withdraw funds on the basis of an unforeseeable emergency may request that the trustee or the trustee's designee reconsider the request by submitting additional written evidence of qualification or reasons why the request for withdrawal of funds from the plan should be approved. All such requests must be in writing and be received by the trustee, or the trustee's designee, within 30 calendar days of the date of the initial denial. Requests received after 30 days will be rejected as untimely, and the initial denial shall become final agency action.

b. Voluntary in-service distribution. A participant who is an active employee of an eligible employer shall receive a distribution of the total amount payable to the participant under the plan if the following requirements are met:

- (1) The total amount payable to the participant under the plan does not exceed \$5,000 (or the dollar limit under IRC Section 411(a)(11), if greater);
- (2) The participant has not previously received an in-service distribution of the total amount payable to the participant under the plan;
- (3) No amount has been deferred under the plan with respect to the participant during the two-year period ending on the date of the in-service distribution; and
- (4) The participant elects to receive the distribution.

The plan administrator may also elect to distribute the accumulated account value of a participant's account without consent, if the above criteria are met.

This provision is available only once in the lifetime of the participating employee. If funds are distributed under this provision, the participating employee is not eligible under the plan to utilize this provision at any other time in the future.

c. Transfers under domestic relations orders.

(1) To the extent required under a final judgment, decree, or order (including approval of a property settlement agreement) made pursuant to a state domestic relations law, any portion of a participating employee's account may be paid or set aside for payment to a spouse, former spouse, or child of the participating employee. The plan will determine whether the judgment, decree, or order is valid and binding on the plan and whether it is issued by a court or agency with jurisdiction over the plan. The judgment, decree or order must specify which of the participating employee's accounts are to be paid or set aside, the valuation date of the accounts and, to the extent possible, the exact value of the accounts. Where necessary to carry out the terms of such an order, a separate account shall be established with respect to the spouse, former spouse, or child who shall be entitled to choose investment providers in the same manner as the participating employee. Unless otherwise subsequently suspended or altered by federal law, all applicable taxes shall be withheld and paid from this lump sum distribution. The provisions of this subparagraph shall not be construed to authorize any amount to be distributed under the plan at a time or in a form that is not permitted under IRC Section 457.

(2) A right to receive benefits under the plan shall be reduced to the extent that any portion of a participating employee's account has been paid or set aside for payment to a spouse, former spouse, or child pursuant to these rules or to the extent that the employer or the plan is otherwise subject to a binding judgment, decree, or order for the attachment, garnishment, or execution of any portion of any account or of any distributions therefrom. The participating employee shall be deemed to have released the employer and the plan from any claim with respect to such amounts in any case in which:

1. The department, the retirement investors' club, or the plan has been served with legal process or otherwise joined in a proceeding relating to such amounts,

2. The participating employee has been notified of the pendency of such proceeding in the manner prescribed by the law of the jurisdiction in which the proceeding is pending for service of process or by mail from the employer or a plan representative to the participating employee's last-known mailing address, and

3. The participating employee fails to obtain an order of the court in the proceeding relieving the employer and the plan from the obligation to comply with the judgment, decree, or order.

(3) The department, the retirement investors' club or the plan shall not be obligated to incur any cost to defend against or set aside any judgment, decree, or order relating to the division, attachment, garnishment, or execution of the participating employee's account or of any distribution therefrom.

64.6(9) *Investment providers.*

a. Participation. The investment providers under the plan are authorized to offer new accounts and investment products to employees only if awarded a contract or service agreement through a competitive bid process. A list of active investment providers shall be provided, upon request, to any employee or other interested party. Inactive investment providers shall participate to the extent necessary to fully discharge their duties under the applicable federal and state laws and regulations, the plan, their service agreements or contracts with the employer, and their investment accounts or contracts with participating employees.

b. Investment products. Investment products shall be limited to those that have been approved by the plan administrator. No new accounts shall be available to employees for life insurance under the plan.

c. Reports and consolidated statements. The investment providers will provide various reports to the plan administrator as well as consolidated statements, newsletters, and performance reports to participants as specified in the service agreements or contracts with investment providers.

d. Dividends and interest. The only dividend or interest options available on policies or funds are those where the dividend or interest remains within the account to increase the value of the account.

e. Minimum contract requirements. In addition to meeting selection requirements, an investment provider must meet and maintain the requirements set forth in its contract or service agreement with the state of Iowa.

f. Removal from participation. Failure to comply with the provisions of these rules, the investment provider contract or service agreement with the employer, or the terms and conditions of the investment provider account with the participating employee may result in termination of an investment provider contract or service agreement, and all rights therein shall be exercised by the employer.

64.6(10) Marketing and education.

a. Orientation and information meetings. Employers may hold orientation and information meetings for the benefit of their employees during normal work hours using materials developed and approved by the plan administrator. Active investment providers may make authorized presentations upon approval of individual agency or department authorities during nonwork hours. There shall be no solicitation of employees by investment providers at an employee's workplace during the employee's working hours, except as authorized in writing by the plan administrator.

b. General requirements for solicitation.

(1) An active investment provider may solicit business from participants and employees through representatives, the mail, or direct presentations.

(2) Active investment providers and representatives may solicit business at an employer's work site only with the prior permission of the agency director or other appropriate authority.

(3) Investment providers or representatives may not conduct any activity with respect to a registered investment option unless the appropriate license has been obtained.

(4) An investment provider or representative may not make a representation about an investment option that is contrary to any attribute of the option or that is misleading with respect to the option.

(5) An investment provider or representative may not state, represent, or imply that its investment options are endorsed or recommended by the plan administrator, the employing agency, the state of Iowa, or an employee of the foregoing.

(6) An investment provider or representative may not state, represent, or imply that its investment option is the only option available under the plan.

c. Disclosure.

(1) Enrollment. When soliciting business for an investment product, an active investment provider or representative shall provide each participating employee or eligible employee with a copy of the approved disclosure for that option. If a variable annuity product has several alternative investment choices, the participant must receive disclosures concerning all investment choices. An active investment provider shall notify the plan administrator in writing if the investment provider will be marketing its investment options through representatives. The notification must contain a complete identification of the representatives who will be marketing the options. Every representative and agent who enrolls eligible employees in the plan and is authorized by the investment provider to sign plan forms must be included on this notification.

(2) Disbursement methods and account values. When discussing distribution methods for an investment option, investment providers or representatives shall disclose to each participating employee or eligible employee all potential distribution methods and the potential income derived from each method for that option.

d. Approval of a disclosure form.

(1) An investment provider shall complete and submit to the plan administrator a disclosure form for each approved investment product. If a variable annuity product has several investment choices, the plan administrator must receive all disclosures related to those investment choices. An investment provider shall complete a disclosure form on each investment product that has participating employee funds (including those no longer offered).

(2) If changes occur during the plan year, any changes must be submitted to the plan administrator for approval prior to their implementation. Disclosure forms will be updated quarterly. Even if no changes occur, an investment provider shall resubmit its disclosure form to the plan administrator for approval every year.

(3) If an investment provider or representative materially misstates a required disclosure or fails to provide disclosure, the plan administrator may sanction the investment provider or bind the investment provider to the disclosure as stated on the form.

e. Confidentiality. The plan administrator may provide to all active investment providers any information that can be made available under the department's rules. Notwithstanding any rule of the department to the contrary, the plan administrator shall make available to all active investment providers the names and home addresses of all state employees. The plan administrator may assess reasonable costs to the active investment providers to defray the expense of producing any requested information. All information obtained under the plan shall be confidential and used exclusively for purposes relating to the plan and as expressly contemplated by the service agreement or contract entered into by the investment provider.

f. Number of investment providers. Only investment providers that are selected through a competitive bid process, that are subsequently awarded a contract or service agreement, and that are authorized to do business in the state of Iowa may sell annuities, mutual funds or other approved products under the plan, and then only if the investment providers agree to the terms, conditions, and provisions of the contract or service agreement.

64.6(11) Investment option removal/replacement. The plan administrator may determine that an investment option offered under the plan is no longer acceptable for inclusion in the plan. If the plan administrator decides to remove an investment option from the plan as the result of the option's failure to meet the established evaluation criteria and according to the recommendations of consultants or advisors, the option shall be removed or phased out of the plan. Employees newly enrolling in the plan shall be informed in writing that investment options that do not meet the evaluation criteria are not open to new enrollments.

a. Notice to participant. Any participating employees already deferring to the investment option being phased out shall be informed in writing that they need to redirect future deferrals from this option to an alternative investment option offered under the plan by notifying the investment provider, unless otherwise directed, of their new investment choice.

b. Automatic transfer. If any participating employee has failed to move a remaining account balance from the investment option being phased out, the plan administrator shall instruct an investment provider to automatically move that participating employee's account balance into another designated alternative investment option offered under the plan.

c. Reexamination. At any time during this process, the plan administrator may reexamine the performance of the investment option being phased out and the recommendations of consultants and advisors to determine if continued inclusion of the investment option in the plan is justified.

64.6(12) Demutualization of investment providers.

a. Ballots. An investment provider that is a mutual company and that provides any annuity product or life insurance product held under the plan shall provide the plan administrator with a ballot(s) for official vote registration. The ballot(s) shall be completed and returned to the company according to the specified deadline in the instructions. The ballot(s) shall include the owner's name, policy numbers of affected contracts, name of annuitant or insured, number of shares anticipated, and the control number for the group of shares.

b. Policyholder booklet. The company shall provide the plan administrator with a policyholder booklet, as well as instructions and guide information, prior to or in conjunction with the delivery of the ballot(s). Notices of progress, time frames and meetings will also be provided to the plan administrator as such information becomes available.

c. Method of compensation. Compensation will be provided in cash according to the terms of the demutualization plan. In the event that stocks are issued in lieu of cash, the company shall provide a listing which includes participants' names, social security numbers, policy numbers, and number of shares pro rata.

d. Liquidation of stock. An arrangement will be entered into between the plan administrator and a stockbroker as soon as administratively possible in order to liquidate the stock for cash. The broker

shall retain commission fees according to the arrangement entered into from the value obtained at the time of sale. The employer will not realize a tax liability nor will the participating employees.

e. Deposit of proceeds. The proceeds of the sale of the stock, less the broker commission, and any dividends issued prior to the sale of the stock, shall be made payable to the plan. Cash shall be deposited into the plan's trust fund until payment instructions are received from the participant or the participant's beneficiary.

[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 1568C, IAB 8/6/14, effective 9/10/14; ARC 4053C, IAB 10/10/18, effective 11/14/18]

11—64.7(8A) Dependent care. The director administers the dependent care flexible spending account plan for employees of the state of Iowa. The plan is permitted under IRC Section 125. The plan is also a dependent care assistance plan under IRC Section 129. Administration of the plan shall comply with all applicable federal regulations, the Plan Document, and the Summary Plan Description. For purposes of this rule, the plan year is a calendar year.

64.7(1) Employee eligibility. All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the dependent care flexible spending plan. Temporary employees are not eligible to participate in this plan.

64.7(2) Enrollment. An open enrollment period, as designated by the director, shall be held for employees who wish to participate in the plan. New employees may enroll within 30 calendar days following their date of hire. Employees also may enroll or change their existing dependent care deduction amounts during the plan year provided that they have a qualifying change in family status as defined in the Plan Document and the Summary Plan Description. To continue participation, employees shall reenroll each year during the open enrollment period.

64.7(3) Termination of participation in the plan. An employee may terminate participation in the plan provided that the employee has a qualifying change in status as defined in the Summary Plan Description. Employees who terminate state employment and are rehired within 30 days must resume their participation in the plan. Employees who terminate state employment and are rehired more than 30 days after termination may reenroll in the plan.

11—64.8(8A) Premium conversion plan (pretax program). The director administers the premium conversion plan for employees of the state of Iowa. The plan is permitted under IRC Section 125. Pursuant to IRC Section 105, the plan is also an insured health care plan to the extent that participants use salary reduction to pay for health or dental insurance premiums. In accordance with IRC Section 79, the plan is also a group term life insurance plan to the extent that salary reduction is used for life insurance premiums. Administration of the plan shall comply with all federal regulations and the Plan Document. For purposes of this rule, the plan year is January 1 to December 31 of each year.

64.8(1) Employee eligibility. All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the pretax conversion plan. Temporary employees are not eligible to participate in the plan.

64.8(2) Enrollment. An enrollment and change period, as designated by the director, shall be held for employees who wish to make changes in their current pretax status. New employees will automatically be enrolled in the plan after satisfying any waiting period requirements for group insurance unless an election form is submitted. Employees also may change their existing pretax status during the plan year if they have a qualifying change in status as defined in the Plan Document.

64.8(3) Termination of participation in the plan. An employee may terminate participation in the plan during an open enrollment period. Otherwise, an employee may terminate participation if the employee has a qualifying change in status as defined in the Plan Document.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.9(8A) Interviewing and moving expense reimbursement.

64.9(1) Interviewing expenses. If reimbursement is approved by the appointing authority, a person who interviews for state employment shall be reimbursed for expenses incurred in order to interview.

Reimbursement shall be at the same rate at which an employee is reimbursed for expenses incurred during the performance of state business.

64.9(2) *Moving expenses for reassigned employees.* A state employee who is reassigned at the direction of the appointing authority shall be reimbursed for moving and related expenses in accordance with the policies of the department of administrative services or the applicable collective bargaining agreement. Eligibility for reimbursement shall occur when all of the following conditions exist:

- a. The employee is reassigned at the direction of the appointing authority;
- b. The reassignment requires a permanent change in duty station beyond 25 miles;
- c. The employee must change the employee's place of personal residence beyond 25 miles unless the department of administrative services has given prior written approval; and
- d. The reassignment is for the primary benefit of the state.

64.9(3) *Moving expenses for newly hired or promoted employees.* If reimbursement is approved by the appointing authority, a person newly hired or promoted may be reimbursed for moving and related expenses. Reimbursement shall be at the same rates used for the reimbursement of a current employee who has been reassigned. Reimbursement shall not occur until the employee is on the payroll.

64.9(4) *Temporary living expenses.* An employee may be reimbursed for up to 90 days of temporary living expenses. Such reimbursement shall be included as part of the total amount reimbursable under the relocation policy.

64.9(5) *Repayment.* As a condition of receiving reimbursement for moving expenses, the recipient must sign an agreement to continue employment with the appointing authority for a period following the date of receipt of reimbursement that is deemed by the appointing authority to be commensurate with the amount of reimbursement received. In the event that the recipient leaves the department of the appointing authority for any reason, the recipient will repay to the appointing authority a proportionate fraction of the amount received for each month remaining in the period provided for in the agreement. If the recipient continues employment with the state, then the repayment will be subject to a repayment schedule approved by the director. If the recipient leaves state government, then the repayment will be recouped out of the final paycheck. Recoupment must be coordinated with the accounting enterprise of the department of administrative services to ensure proper tax reporting.

11—64.10(8A) Education financial assistance. Education financial assistance may be granted for the purpose of assisting employees in developing skills that will improve their ability to perform job responsibilities. Assistance may be in the form of direct payment to the organization or institution or by reimbursement to the employee as provided for in subrule 64.10(4).

64.10(1) *Employee eligibility.* Any nontemporary employee may be considered for education financial assistance.

64.10(2) *Workshop, seminar, or conference attendance.* The appointing authority may approve education financial assistance for an employee attending a workshop, seminar, or conference conducted by a professional, educational, or governmental organization or institution when attendance by the employee would not require a reduction in job responsibilities.

a. Assistance for meeting continuing education requirements may be approved when the assistance is applied toward maintaining a professional registration, certification, or license and the workshop, seminar, or conference is related to the duties and responsibilities of the employee's position.

b. Payment of registration fees and other costs, such as lodging, meals, and travel, shall be in accordance with the policies and procedures of the department of administrative services.

c. If attendance is outside the state of Iowa, travel must be authorized pursuant to Iowa Code section 8A.512A(2) "a."

64.10(3) *Educational institution coursework.* Education financial assistance to an employee taking academic courses at an educational institution, with or without educational leave, shall require the preapproval of the appointing authority and the director. Requests for reimbursement shall be on forms prescribed by the director.

a. An employee may take academic courses at any accredited educational institution (university, college, area community college) within the state. Attendance at an out-of-state institution may be

approved provided that there are geographical or educational considerations which make attendance within the state impractical.

b. Reimbursement requests shall be made to the director before the employee takes the courses. If the director does not approve the request, the employee shall not be reimbursed.

c. Reimbursement may be approved for courses taken to meet continuing education requirements when necessary to maintain a professional registration, certification, or license when the courses relate to the duties and responsibilities of the employee's position.

d. An employee receiving other financial assistance, such as scholarship aid or Veterans Administration assistance, shall be eligible to receive education financial assistance only to the extent that the total of all methods of reimbursement does not exceed 100 percent of the payment of expenses.

e. In order for the employee to be reimbursed, the employee's department shall submit to the department of administrative services the employee's original paid receipt from the educational institution, the approved education financial assistance form, and proof of the employee's successful completion of the courses as follows:

- (1) Undergraduate courses shall require at least a "C-" grade.
- (2) Graduate courses shall require at least a "B-" grade.
- (3) Successful completion of vocational or correspondence courses or continuing education courses shall require an official certificate, diploma or notice.

64.10(4) *Repayment.* As a condition of applying for reimbursement for education expenses, the recipient must sign an agreement to continue employment with the appointing authority. The agreement must be signed prior to approval and will stipulate the period of time deemed by the appointing authority to be commensurate with the amount of reimbursement received. The period of time commences upon successful completion of the course. In the event that the recipient leaves the department of the appointing authority for any reason, the recipient will repay to the appointing authority an appropriate fraction of the amount received for each month remaining in the period provided for in the agreement. If the recipient continues employment with the state, then the repayment will be subject to a repayment schedule approved by the director. If the recipient leaves state government, then the repayment will be recouped out of the final paycheck. Recoupment must be coordinated with the accounting enterprise of the department of administrative services to ensure proper tax reporting.

64.10(5) *Annual report.* Rescinded IAB 11/21/18, effective 12/26/18.
[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 2267C, IAB 11/25/15, effective 12/30/15; ARC 3041C, IAB 4/26/17, effective 5/31/17; ARC 4134C, IAB 11/21/18, effective 12/26/18; ARC 6236C, IAB 3/9/22, effective 4/13/22]

11—64.11(8A) Particular contracts governing. Where provisions of collective bargaining agreements differ from the provisions of this chapter, the provisions of the collective bargaining agreement shall prevail for employees covered by the collective bargaining agreements.

11—64.12(8A) Tax-sheltered annuities (TSAs).

64.12(1) *Administration.* The director is authorized by 2003 Iowa Code Supplement section 8A.402 to administer a tax-sheltered annuity program for eligible employees.

64.12(2) *Definitions.* The following definitions shall apply when used in this rule:

"Company" means any life insurance company or mutual fund provider that issues a policy under the tax-sheltered annuity plan authorized under Iowa Code section 8A.438.

"Employee" means an employee of the state of Iowa, including employees of the board of regents administrative staff on the centralized payroll system, or an employee of a participating employer.

"Employer" means the state of Iowa, a public school district in the state of Iowa, an area education agency in the state of Iowa, or a community college in the state of Iowa.

"Participating employee" means an employee participating in the plan.

"Participating employer" means an employer that has elected to join the state's tax-sheltered annuity plan.

"Plan" means the tax-sheltered annuity plan authorized in Iowa Code section 8A.438.

"Plan administrator" means the designee of the director who is authorized to administer the tax-sheltered annuity plan.

“*Plan year*” means a calendar year.

“*Policy*” means any retirement annuity, variable annuity, family of mutual funds or combination thereof provided by IRC Section 403(b) and Iowa Code section 8A.438.

“*Salary reduction form*” means the tax-sheltered annuity form signed by the participating employee to begin or change payroll deductions.

64.12(3) Eligibility.

a. Initial eligibility. Any employee who works for the department of education, the board of regents administrative office, or a participating employer is eligible to participate in this plan. Participating employers may establish different eligibility requirements, as long as the requirements conform to IRC Section 403(b) and the applicable federal regulations. Final determination on eligibility shall rest with the plan administrator.

b. Eligibility after terminating reduction of compensation. Any employee who terminates the reduction of compensation may choose to reenroll in the plan in accordance with paragraphs 64.12(4) “a” and “b” and 64.12(6) “a.”

64.12(4) Enrollment and termination.

a. Enrollment. State employees may enroll in the plan at any time. Participating employers may establish different enrollment periods, as long as the periods conform to IRC Section 403(b) and the applicable federal regulations. The salary reduction form must be submitted to the employing agency’s personnel assistant or payroll office for approval.

b. Forms submission. State personnel assistants shall provide the plan administrator with the salary reduction form in a timely manner.

c. Termination of salary reductions. A participating employee may terminate salary reductions by providing to the employing agency’s personnel assistant or payroll office written notification on a form required by the plan administrator.

d. Availability of forms. It is the responsibility of each employee interested in participating in the plan to obtain the necessary forms from the investment provider.

64.12(5) Tax status.

a. FICA and IPERS. The amount of compensation reduced under the salary reduction form shall be included in the gross wages subject to FICA and IPERS until the maximum taxable wages established by law have been reached.

b. Federal and state income taxes. The amount of earned compensation reduced under the form is exempt from federal and state income taxes until such time as the funds are paid or made available as provided in IRC Section 403(b).

64.12(6) Reductions from earnings.

a. Salary reduction amount changes. Participating employees may increase or decrease their salary reduction amount by providing to their personnel assistant or payroll office written notice on a form required by the plan administrator. Salary reduction amounts may be changed to permit a one-time lump sum contribution from the last paycheck due to termination of employment.

b. Maximum salary reduction limits. Employees’ salary reductions may not exceed the maximum limit set forth in federal law.

c. Minimum salary reduction amount. Participating employers may establish a minimum amount as long as the minimum conforms to IRC Section 403(b) and the applicable federal regulations.

64.12(7) Companies.

a. Time of payment. Participating employers shall transmit amounts within 15 business days after the end of the calendar month.

b. Cooperation with third-party administrator. Companies are required to cooperate with the plan’s third-party administrator, including the provision of daily account information as well as any other data or information required for administration of the plan.

c. Annual status report. Each company shall provide to the participating employee at the employee’s home address an annual status report stating the value of each participant’s policy. This practice shall be continued even after the participating employee terminates or stops contributions to the

plan. These annual reports are required as long as a value exists in the contract or any activity occurs during the year.

d. Crediting of accounts. Companies must minimize crediting errors and provide timely and reasonable credit resolution.

e. Solicitation. There shall be no solicitation of employees by companies at the employees' workplace during employees' work hours, except as authorized by the plan administrator or participating employer.

f. Dividends. The only dividend options available on cash value policies are those where the dividend remains with the company to increase the value of the policy.

g. Removal from participation. Failure to comply with the provisions of these rules will result in permanent removal as a participating company and may require that the monthly ongoing deferrals to existing contracts be discontinued, as determined by the director.

64.12(8) Disposition of funds.

a. Distribution eligibility. An employee is eligible for a distribution of funds based upon any of the following circumstances: severance of employment; reaching age 59½; becoming disabled; qualifying for a financial hardship; or becoming eligible for a reservist distribution. Distribution will be made in accordance with applicable IRS regulations.

b. Financial hardship. A participating employee may request to withdraw some or all of the salary reduction contributions to the policy, but not the income earned thereon, based on a financial hardship and in accordance with 401(k) regulations. New contributions to the plan will not be allowed after the receipt of a distribution based on financial hardship until such time as allowed by law.

c. Federal and state withholding taxes. It is the company's responsibility, when making payments to an employee, to withhold the required federal and state income tax, to timely remit the tax to the proper government agency, and to file all necessary reports as required by federal and state regulations, including IRS Form 1099-R.

d. Federal penalties. Under IRC Section 72(t), an additional tax of 10 percent of the amount includable in gross income applies to early withdrawal for qualified plans as defined in IRC Section 4974(c). An IRC Section 403(b) contract is a qualified plan for these purposes.

64.12(9) General.

a. Orientation and information meetings. Employers may hold orientation and information meetings for the benefit of their employees using materials developed or approved by the plan administrator, but there shall be no solicitation of employees by companies allowed at such meetings without employer approval.

b. Company changes.

(1) If a participating employee wishes to redirect contributions to another company, the employee shall submit a form to the personnel assistant or payroll office in accordance with paragraph 64.12(6) "a."

(2) The funds accumulated under the old policy may be transferred in total to the new policy or to another existing policy, if allowed under the participating employer's plan elections, in accordance with the plan's policies and applicable IRC Section 403(b) provisions.

c. Deferred compensation or tax-sheltered annuity participation—maximum contribution. State employees who, under the laws of the state of Iowa, are eligible for both deferred compensation and tax-sheltered annuities shall be allowed to contribute to one plan or the other, but not to both at the same time.

d. Direct transfer/rollover.

(1) Effective January 1, 2002, a former employee may request a direct transfer/rollover to an eligible retirement plan as defined in IRC Section 402(c)(8)(B). Eligible rollover amounts that are received by a former employee are subject to mandatory federal and state withholding as required by law.

(2) An employee may request a trustee-to-trustee transfer of funds to a defined benefit governmental plan for the purchase of permissive service credit.

64.12(10) Forfeiture. IRC Section 403(b)(1)(C) provides that an employee's interest in an IRC Section 403(b) contract is nonforfeitable, except for failure to pay future premiums.

64.12(11) *Nontransferability.* The employee's interest in the contract is nontransferable within the meaning of IRC Section 401(g). The contract may not be sold, assigned, discounted, or pledged as collateral for a loan or as security for the performance of an obligation or for any other purpose.
[ARC 8265B, IAB 11/4/09, effective 12/9/09]

11—64.13(8A) Health flexible spending account. The director administers the health flexible spending account plan for employees of the state of Iowa. The program is permitted under IRC Section 125. Administration of the plan shall comply with all applicable federal regulations and the Plan Document. To the extent that the provisions of the Plan Document or administrative rule conflict with IRC Section 125, the provisions of IRC Section 125 shall govern. For purposes of this rule, the plan year is a calendar year.

64.13(1) *Employee eligibility.* All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the health flexible spending account plan. Temporary employees are not eligible to participate in this plan.

64.13(2) *Enrollment.* An open enrollment period, as designated by the director, shall be held for employees who wish to participate in the plan. New employees may enroll within 30 calendar days following their date of hire. Employees also may enroll or change their existing health flexible spending account salary reduction amounts during the plan year, provided they have a qualifying change in status as defined in the Plan Document, and as permitted under IRC Section 125. To continue participation, employees shall reenroll each year during the open enrollment period.

64.13(3) *Modification or termination of participation in the plan.* An employee may modify or terminate participation in the plan, provided the employee has a qualifying change in status as defined in the Plan Document, and as permitted under IRC Section 125. Employees who have terminated state employment and are rehired within 30 days must resume their participation in the plan. Employees who terminate state employment and are rehired more than 30 days after termination may reenroll in the plan.

64.13(4) *Continuation of coverage.* The health flexible spending account plan shall provide the opportunity to continue coverage as required by applicable state and federal laws.

64.13(5) *Eligible health care expenses.* The types of expenses eligible for reimbursement shall be consistent with medical expenses as defined under IRC Section 213.

64.13(6) *Acceptable proof of eligible expense.* Only those expenses for which appropriate documentation is submitted shall be eligible for reimbursement. Such documentation shall include the date upon which the expense was incurred; sufficient evidence that the expense is an eligible health care expense; evidence that the expense has been incurred and will not be reimbursed under an otherwise qualified health plan authorized by IRC Sections 105 and 106; and the amount of such expense.

64.13(7) *Appeal process.* In the event that a participant disagrees with a determination as to reimbursement from the health flexible spending account plan, a formal appeals mechanism is hereby provided. The participant may submit a formal appeal in writing to the director (or designee). Such appeal must be accompanied by a previous written request for favorable consideration to the designated administrator of the plan, along with evidence as to an unfavorable determination in response to this request. Upon receipt of a qualified appeal, the director (or designee) shall provide a written determination within 30 days of receipt. Such determination shall be final and binding. This appeal process is not a contested case proceeding as defined by Iowa Code chapter 17A.

64.13(8) *Third-party administrator.* The director may contract with a third-party administrator to perform such actions as are reasonably necessary to administer the health flexible spending account plan.
[ARC 3215C, IAB 7/19/17, effective 7/1/17]

11—64.14(8A) Deferred compensation match plan. The director is authorized by the governing body to administer a deferred compensation match plan for employees of the state of Iowa and employees of other eligible participating governmental employers. The plan shall be qualified under IRC Section 401(a) and Iowa Code section 509A.12. The assets and income of the plan shall be held in trust for the exclusive benefit of the participating employee or the participating employee's beneficiary. The trustee shall be the director of the department of administrative services. The director shall adopt various

investment options for the investment of plan funds by participating employees or their beneficiaries and shall monitor and evaluate the appropriateness of the investment options offered by the plan.

The plan shall match eligible participant contributions to the deferred compensation plan with contributions by the employer. Eligibility of participants and the rate of employer matching contributions shall be subject to determination by the trustee and the governing body. The only voluntary contributions by participants that the plan shall accept are eligible rollover contributions.

11—64.15(8A) Insurance benefit eligibility.

64.15(1) Full-time and part-time employees with probationary or permanent status who work 20 or more hours a week are eligible for health and dental insurance coverage. For employees working 20 to 29 hours per week, the state's share of the premium is one-half the amount paid for full-time employees (30 to 40 hours per week). Temporary employees are not eligible for health or dental insurance.

64.15(2) Full-time employees with probationary or permanent status who work 30 or more hours a week are eligible for life and long-term disability insurance coverage. Temporary employees are not eligible for life and long-term disability insurance.

64.15(3) The surviving spouse and each surviving child of an eligible peace officer or fire fighter, as defined in Iowa Code section 509A.13C, are eligible for the continuation of existing, or reenrollment in previously existing, health insurance coverage.

64.15(4) The surviving spouse and each surviving child of an eligible employee of the Iowa department of corrections, as defined in Iowa Code section 509A.13D, are eligible for the continuation of existing, or reenrollment in previously existing, health insurance coverage.

[ARC 4136C, IAB 11/21/18, effective 12/26/18; ARC 6089C, IAB 12/15/21, effective 1/19/22]

11—64.16(8A) Sick leave insurance program. The director is authorized to establish a sick leave insurance program (program) for employees. The program shall allow eligible employees to convert a portion of their sick leave balance at retirement into a sick leave bank with which the state will pay the state's share of retiree health insurance. Employees of the department of natural resources or department of public safety who are classified as peace officers and are not covered by a collective bargaining agreement shall receive benefits at retirement consistent with the provisions of the negotiated collective bargaining agreement with the State Police Officers Council. The benefits for sick leave banks earned by all department of public safety peace officer employees shall be administered by the department of public safety.

64.16(1) To be eligible to participate in the program, the employee must be employed on or after July 1, 2006, and must retire under a retirement system in the state maintained in whole or in part by public contributions or payment prior to reaching Medicare eligibility.

a. Participation in the program ceases when any one of the following occurs:

- (1) The employee's sick leave balance is exhausted;
- (2) The employee reaches Medicare eligibility;
- (3) The employee terminates participation in the state's group insurance program;
- (4) The employee returns to permanent employment with the state;
- (5) The employee fails to pay any required amount; or
- (6) The employee dies.

b. A deceased employee's sick leave bank is not transferable to another person, including a spouse.

64.16(2) Upon a participating employee's termination of employment, the employee's sick leave hours are multiplied by the employee's regular hourly wage. The employee receives up to \$2,000 of this amount on the employee's final paycheck. The remainder is multiplied by a conversion factor, and that amount is placed into the employee's sick leave bank. The conversion factors are as follows: If an employee has up to 750 hours, the rate is 60 percent; if an employee has over 750 hours and up to 1,500 hours, the rate is 80 percent; and if the employee has more than 1,500 hours, the rate is 100 percent. The employee's sick leave balance before payment of up to \$2,000 is used to determine the number of hours an employee has for conversion purposes. The amounts placed into the employee's sick leave bank have no cash value, other than for purposes of paying the state's share of retiree health insurance premiums

under this program. The value of sick leave hours for peace officer employees of the department of natural resources and the department of public safety shall be calculated in the same manner as for those employees covered by the collective bargaining agreement with the State Police Officers Council.

64.16(3) Rescinded IAB 5/27/15, effective 7/1/15.

64.16(4) To participate in the program, an employee must complete a sick leave insurance program enrollment form upon retirement. Upon commencement of participation in the program, the employee may choose to continue the employee's current health insurance plan selection or may choose any other state group health plan whose total cost is the same or lower than the total cost of the current plan selection. Except for employees eligible for benefits negotiated consistent with the collective bargaining agreement negotiated with the State Police Officers Council, employees may not apply the sick leave balance to a private insurance plan.

[ARC 2000C, IAB 5/27/15, effective 7/1/15; ARC 3215C, IAB 7/19/17, effective 7/1/17]

These rules are intended to implement Iowa Code sections 8A.402, 8A.433 to 8A.438, and 8A.454 and Iowa Code chapter 509A.

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CHAPTER 38
ASSURANCE OF VOLUNTARY COMPLIANCE

61—38.1(714) Assurance of voluntary compliance. In any case where the attorney general has authority to institute a civil action or proceeding pursuant to Iowa Code section 714.16(7), in lieu thereof, the attorney general may accept an assurance of voluntary compliance with respect to any method, act or practice deemed to be in violation of the Iowa consumer fraud Act from any person who has engaged in, is engaging in, or was about to engage in such method, act or practice. Such assurance may, among other terms, include a stipulation for the voluntary payment by such person of the costs of investigation, the voluntary payment of a civil penalty, or an amount to be held in escrow pending the outcome of an action or as restitution to aggrieved consumers, or both. Matters thus closed may at any time be reopened by the attorney general for further proceedings in the public interest.

An assurance entered into pursuant to this rule shall not be considered an admission of a violation, provided that violation of such an assurance shall be treated as a violation of Iowa Code section 714.16, and shall be subjected to all the penalties and remedies provided therefor. A finding by a court that a violation of such assurance of voluntary compliance has occurred shall establish a prima facie case that the person subject thereto knows, or in the exercise of due care should know, that the person has in the past violated or is intentionally violating the provisions of this chapter.

[ARC 6231C, IAB 3/9/22, effective 4/13/22]

This rule is intended to implement Iowa Code section 714.16(7).

[Filed ARC 6231C (Notice ARC 6145C, IAB 1/12/22), IAB 3/9/22, effective 4/13/22]

ECONOMIC DEVELOPMENT AUTHORITY[261]

[Created by 1986 Iowa Acts, chapter 1245]

[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

[Prior to 9/7/11, see Economic Development, Iowa Department of[261];
renamed Economic Development Authority by 2011 Iowa Acts, House File 590]

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261—23.1(15) Purpose. The primary purpose of the community development block grant program is the development of viable communities by providing decent housing and suitable living environments and expanding economic opportunities, primarily for persons of low and moderate income.

261—23.2(15) Definitions. When used in this chapter, unless the context otherwise requires:

“*Annual action plan*” means the annual plan required and approved by the U.S. Department of Housing and Urban Development that outlines the state’s processes and procedures for distribution of CDBG funds. The annual action plan is available on the authority’s website.

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Authority’s website*” means the information and related content found at www.iowaeda.com and may include integrated content at affiliate sites.

“*CDBG*” means community development block grant.

“*Citizen participation plan*” means the plan required and approved by the U.S. Department of Housing and Urban Development that describes the state’s process for including citizen participation in development of its consolidated plan and annual action plan. The citizen participation plan is available on the authority’s website.

“*Consolidated plan*” means the five-year plan required and approved by the U.S. Department of Housing and Urban Development that establishes goals and objectives for the state’s CDBG program. The consolidated plan is available on the authority’s website.

“*HUD*” means the U.S. Department of Housing and Urban Development.

“*Management guide*” means the administrative reference manual published by the authority for each program year. The management guide is available on the authority’s website.

“*Program year*” means the annual period beginning January 1 and ending December 31.

“*Recipient*” means a local government entity awarded CDBG funds under any CDBG program.

“*Subrecipient*” means a public or nonprofit entity contracting with and receiving funds from a recipient to carry out CDBG project activities.

[ARC 7970B, IAB 7/15/09, effective 7/1/09; ARC 8145B, IAB 9/23/09, effective 10/28/09; ARC 2038C, IAB 6/24/15, effective 7/29/15; ARC 6241C, IAB 3/9/22, effective 4/13/22]

261—23.3(15) Annual action plan. The authority will prepare a CDBG annual action plan for submittal to and approval by HUD. The plan will provide a description of the activities and programs that will take place during the year to meet goals established in the consolidated plan.

23.3(1) The authority will follow the state’s citizen participation plan during the development of the annual action plan. A draft annual action plan will be available on the authority’s website for 30 days for public review and comment. The authority will hold a public hearing during the comment period to collect public input on the plan prior to its submittal to HUD.

23.3(2) The annual action plan will be submitted to HUD by November 15 of each year or 60 days after HUD announces the annual allocation amount. Upon review and approval by HUD, the annual action plan will cover activities from January 1 to December 31 of the year following plan submittal to HUD.

23.3(3) The annual action plan will include the proposed CDBG program funding allocation.

[ARC 2038C, IAB 6/24/15, effective 7/29/15; ARC 6241C, IAB 3/9/22, effective 4/13/22]

261—23.4(15) Allocation of funds. Upon approval by HUD, the authority will annually allocate CDBG funds among programs or activities described in the state’s most recent annual action plan, which may include, but not be limited to, the following:

1. Housing assistance.
2. Job training and employment-related transportation services.
3. Water and sewer improvements.
4. Community facilities improvements.

5. Opportunities and threats fund.
6. Business or microenterprise assistance.
7. Neighborhood revitalization activities.

[ARC 2038C, IAB 6/24/15, effective 7/29/15; ARC 6241C, IAB 3/9/22, effective 4/13/22]

261—23.5(15) Requirements for funding. Applications for funds under any of the program-allocated funds pursuant to rule 261—23.4(15) shall meet the minimum criteria described in subrules 23.5(1) through 23.5(3).

23.5(1) Proposed activities shall be eligible, as authorized by Title I, Section 105 of the Housing and Community Development Act of 1974, as amended, and as further defined in 24 CFR Part 570.

23.5(2) Proposed activities shall address at least one of the following three objectives:

a. Primarily benefit low- and moderate-income persons. To address this objective, 51 percent or more persons benefiting from a proposed activity must have incomes at or below 80 percent of the area median income.

b. Aid in the prevention or elimination of slums and blight. To address this objective, the application must document the extent or seriousness of deterioration in the area to be assisted, showing a clear adverse effect on the well-being of the area or community and illustrating that the proposed activity will alleviate or eliminate the conditions causing the deterioration.

c. Meet an urgent community development need. To address this objective, the applicant must certify that the proposed activity is designed to alleviate existing conditions that pose a serious and immediate threat to the health or welfare of the community and that are recent in origin or that recently became urgent; that the applicant is unable to finance the activity without CDBG assistance and that other sources of funding are not available.

23.5(3) Applicants shall certify their compliance with federal requirements applicable to the CDBG program including, but not limited to, the following:

a. The Civil Rights Act of 1964 (PL 88-352) and Title VIII of the Civil Rights Act of 1968 (PL 90-284) and related civil rights, fair housing and equal opportunity statutes and orders;

b. Title I of the Housing and Community Development Act of 1974;

c. Age Discrimination Act of 1975;

d. Section 504 of the Housing and Urban Development Act of 1973;

e. Section 3 of the Housing and Urban Development Act of 1968;

f. Davis-Bacon Act (40 U.S.C. 276a-5) where applicable under Section 100 of the Housing and Community Development Act of 1974;

g. Lead-Based Paint Poisoning Prevention Act;

h. 24 CFR Part 58 and the National Environmental Policy Act of 1969;

i. Uniform Relocation Assistance and Real Property Acquisition Act of 1979, Titles II and III;

j. Americans with Disabilities Act;

k. Section 102 of the Department of Housing and Urban Development Reform Act of 1989;

l. Contract Work Hours and Safety Act;

m. Copeland Anti-Kickback Act;

n. Fair Labor Standards Act;

o. Hatch Act;

p. Prohibition on the Use of Excessive Force and Barring Entrance;

q. Drug-Free Workplace Act;

r. Governmentwide Restriction on Lobbying;

s. Single Audit Act;

t. State of Iowa Citizen Participation Plan; and

u. Other relevant regulations as noted in the CDBG management guide.

[ARC 2038C, IAB 6/24/15, effective 7/29/15; ARC 6241C, IAB 3/9/22, effective 4/13/22]

261—23.6(15) Award and administration. The authority may negotiate award amounts, terms and conditions prior to making any award under the program. Recipients shall comply with requirements and instructions set forth in the applicable CDBG management guide.
[ARC 6241C, IAB 3/9/22, effective 4/13/22]

261—23.7(15) Requirements for the economic development set-aside fund. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.8(15) Requirements for the public facilities set-aside fund. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.9(15) Requirements for the career link program. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.10(15) Requirements for the opportunities and threats fund. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.11(15) Requirements for the housing fund program. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.12(15) Interim financing program. Rescinded ARC 2038C, IAB 6/24/15, effective 7/29/15.

261—23.13(15) Flood recovery fund. Rescinded IAB 9/18/02, effective 10/23/02.

261—23.14(15) Disaster recovery fund. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.15(15) Administration of a CDBG award. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.16(15) Requirements for the downtown revitalization fund. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

261—23.17(15) Section 108 Loan Guarantee Program. Rescinded ARC 6241C, IAB 3/9/22, effective 4/13/22.

These rules are intended to implement Iowa Code section 15.108(1)“a.”

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- [Filed ARC 6241C (Notice ARC 6139C, IAB 1/12/22), IAB 3/9/22, effective 4/13/22]

¹ See IAB Economic Development Department.

CHAPTER 115
TAX CREDITS FOR INVESTMENTS IN QUALIFYING BUSINESSES

261—115.1(15E) Tax credits for investments in qualifying businesses. Tax credits for investments in qualifying businesses may be claimed as provided in this rule and any applicable rules of the department of revenue.

115.1(1) Tax credits allowed only after a certain date. A taxpayer may claim a tax credit under this rule for equity investments in certain qualifying businesses. Only equity investments made on or after January 1, 2011, qualify for a tax credit under this rule. Equity investments made before that date must be claimed under 123—Chapter 2.

115.1(2) Investments in qualifying businesses.

a. A taxpayer may claim a tax credit under this subrule for a portion of the taxpayer's equity investment in a qualifying business if that investment was made on or after January 1, 2011.

b. The tax credit may be claimed against the taxpayer's tax liability for any of the following taxes:

- (1) The personal net income tax imposed under Iowa Code chapter 422, division II.
- (2) The business tax on corporations imposed under Iowa Code chapter 422, division III.
- (3) The franchise tax on financial institutions imposed under Iowa Code chapter 422, division V.
- (4) The tax on the gross premiums of insurance companies imposed under Iowa Code chapter 432.
- (5) The tax on moneys and credits imposed under Iowa Code section 533.329.

c. Investments made in qualifying businesses on or after January 1, 2011, and before July 2, 2015, are governed by 2015 Iowa Code sections 15E.41 to 15E.46, 422.11F, 422.33, 422.60, 432.12C, and 533.329.

d. Investments made in qualifying businesses on or after July 2, 2015, are governed by 2016 Iowa Code sections 15E.41 to 15E.46, 422.11F, 422.33, 422.60, 432.12C, and 533.329.

115.1(3) Amount of tax credit that may be claimed by taxpayer.

a. In the case of investments made on or after July 2, 2015, the amount of tax credit available to a taxpayer under this rule is equal to 25 percent of the taxpayer's equity investment in a qualifying business.

b. In the case of investments made on or after July 2, 2015, the maximum amount of tax credit that may be issued per calendar year to a natural person and the person's spouse or dependent shall not exceed \$100,000 combined. For purposes of this paragraph, a tax credit issued to a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual shall be deemed to be issued to the individual owners based upon the pro rata share of the individual's earnings from the entity. For purposes of this paragraph, "dependent" has the same meaning as provided by the Internal Revenue Code. Applications received by the authority that exceed the maximum amount of tax credits per calendar year to a natural person and the person's spouse or dependent will be denied by the board, regardless of whether the investment was otherwise eligible to receive a tax credit award. Any application that can be partially approved without exceeding the maximum amount in this paragraph will be approved as to the portion less than the maximum amount and denied as to the portion greater than the maximum amount. For example, if an application is eligible for \$50,000 of tax credits, but there is only \$30,000 of the household maximum amount available, the application will be approved for \$30,000 and denied for \$20,000.

c. The maximum amount of tax credits that may be issued per calendar year for equity investments in any one qualifying business shall not exceed \$500,000. Applications received by the authority that exceed the maximum amount of tax credits per calendar year in any one qualifying business will be denied by the board, regardless of whether the investment was otherwise eligible to receive a tax credit award. Any application that can be partially approved without exceeding the maximum amount in this paragraph will be approved as to the portion less than the maximum amount and denied as to the portion greater than the maximum amount. For example, if an application is eligible for \$50,000 of tax credits,

but there is only \$30,000 of the business maximum amount available, the application will be approved for \$30,000 and denied for \$20,000.

115.1(4) Claiming an investment tax credit. A taxpayer that makes an investment in a qualifying business and that otherwise meets the requirements of this chapter will receive a board-approved tax credit certificate from the authority. To claim the credit, the taxpayer must include the certificate with a tax return filed with the department of revenue. For more information on claiming the tax credit, see department of revenue rules 701—42.22(15E,422), 701—52.21(15E,422), and 701—58.11(15E,422). [ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.2(15E) Definitions. For purposes of this chapter, unless the context otherwise requires:

“*Affiliate*” means a spouse, child, or sibling of an investor or a corporation, partnership, or trust in which an investor has a controlling equity interest or in which an investor exercises management control.

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Board*” means the members of the economic development authority appointed by the governor and in whom the powers of the authority are vested pursuant to Iowa Code section 15.105.

“*Controlling equity interest*” means ownership of more than 50 percent of the outstanding equity interests of a corporation, partnership, limited liability company or trust.

“*Convertible debt*” means debt that may be converted to equity at the option of the debt holder but has not yet been converted.

“*Entrepreneurial assistance program*” includes the entrepreneur investment awards program administered under Iowa Code section 15E.362, the receipt of services from a service provider engaged pursuant to Iowa Code section 15.411(1) or the program administered under Iowa Code section 15.411(2).

“*Equity*” means common or preferred corporate stock or warrants to acquire such stock, membership interests in limited liability companies, or partnership interests in partnerships. Equity shall be limited to securities or interests acquired only for cash and shall not include securities or interests acquired at any time for services, contributions of property other than cash, convertible debt, or any other non-cash consideration.

“*Investor*” means a person that makes a cash investment in a qualifying business on or after July 2, 2015. “Investor” does not include a person that holds at least a 70 percent ownership interest as an owner, member, or shareholder in a qualifying business.

“*Management control*” means holding more than 50 percent of the voting power on any board of directors or trustees, any management committee, or any other group managing a corporation, partnership, limited liability company or trust.

“*Person*” means an individual, corporation, limited liability company, business trust, estate, trust, partnership or association, or any other legal entity.

“*Qualifying business*” means a business that meets the criteria listed in subrule 115.5(2).

“*Services requiring a professional license*” includes but is not limited to the professions listed in Iowa Code section 496C.2.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.3(15E) Cash investments required. In order to qualify for a tax credit under this chapter, the taxpayer’s investment must be made in the form of cash to purchase equity in a qualifying business. Convertible debt shall only be considered an investment in the form of cash to purchase equity as of the date of conversion.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.4(15E) Applying for an investment tax credit.

115.4(1) A taxpayer that desires to receive an investment tax credit for an equity investment in a qualifying business shall submit an application to the board for approval and provide such other information and documentation as may be requested by the board. Application forms for the investment tax credit may be obtained by contacting a qualifying business that has received a notice of certification pursuant to rule 261—115.5(15E).

115.4(2) Applications shall be date- and time-stamped by the authority in the order in which such applications are received. Applications for the investment tax credit shall be accepted by the authority until March 31 of the year following the calendar year in which the taxpayer's equity investment was made. Investors who do not submit an application by the March 31 deadline are ineligible to receive a tax credit.

EXAMPLE 1: A taxpayer makes an equity investment in a qualifying business on December 31, 2011. The taxpayer has until March 31, 2012, to apply to the authority for an investment tax credit.

EXAMPLE 2: A taxpayer makes an equity investment in a qualifying business on July 1, 2012. The taxpayer has until March 31, 2013, to apply to the authority for an investment tax credit.

The authority may accept applications after the deadline under extenuating circumstances. The authority shall not consider the lack of an available application filing window pursuant to paragraph 115.6(6) "b" as an extenuating circumstance.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.5(15E) Certification of qualifying businesses.

115.5(1) *Application for certification.* Within 120 days from the first date on which the equity investments qualifying for investment tax credits have been made, a qualifying business shall apply to the authority for certification as a qualifying business as prescribed by the authority. Investments made more than 120 days prior to receipt by the authority of a substantially complete application for certification shall not be eligible for a tax credit. The application for certification will include the following information:

a. A description of the general nature of the business's operations, the location of the principal business operations, the date on which the business was formed, and the date on which the business commenced operations;

b. A balance sheet that reflects the qualifying business's assets, liabilities and owner's equity as of the close of the most recent month or quarter;

c. A description of the manner in which the business satisfies one of the business experience requirements set forth in paragraph 115.5(2) "c";

d. The names, addresses, shares or equity interests issued, consideration paid for the shares or equity interests, and amounts of any tax credits of all shareholders or equity holders who may initially qualify for the tax credits and the date on which the investment was made. The application shall contain a commitment by the qualifying business to amend its list of investors as may be necessary from time to time to reflect new equity interests or transfers in equity among current equity holders or as any other information on the list may change. Applications for tax credits for investments that are not reflected on the most recent listing of investors provided to the authority shall not be eligible for tax credits until an amended list is provided by the qualifying business;

e. A signed statement from an officer, director, manager, member, or general partner of the qualifying business certifying the accuracy of the information provided; and

f. Any other information as the authority may reasonably require to determine the business's eligibility for certification as a qualifying business and its investors' eligibility to receive tax credits.

115.5(2) *Eligibility for certification as a qualifying business.* A business shall meet all of the following criteria to be eligible for certification as a qualifying business:

a. The principal business operations of the business are located in the state of Iowa;

b. The business has been in operation for six years or less, as measured from the date of the investment for which a credit is claimed;

c. The business is participating in an entrepreneurial assistance program. The authority may waive this requirement if a business establishes that its owners, directors, officers, and employees have an appropriate level of experience such that participation in an entrepreneurial assistance program would not materially change the prospects of the business. The authority may consult with outside service providers in consideration of such a waiver;

d. The business is not a business engaged primarily in retail sales, real estate, or the provision of health care services or other services requiring a professional license. In determining whether a business

is primarily engaged in retail sales, factors the authority will consider include, but are not limited to, the sources of the business's revenue, whether the business manufactures a product it sells, and whether the business owns intellectual property associated with a product it sells;

e. The business does not have a net worth that exceeds \$10 million as of the date of the investment for which the credit is claimed; and

f. The business shall have secured all of the following at the time of application for tax credits:

(1) At least two investors.

(2) Total equity financing, binding equity investment commitments, or some combination thereof, equal to at least \$500,000 from investors. For the purposes of determining whether a business has secured at least \$500,000 from investors, convertible debt shall only be considered equity as of the date of conversion.

For purposes of paragraph 115.5(2) "*f.*" "investor" includes a person that executes a binding investment commitment to a business.

115.5(3) Authority review and notice of certification.

a. Upon the authority's receipt of the information and documentation necessary to demonstrate satisfaction of the criteria set forth in subrule 115.5(2), the authority shall, within a reasonable period of time, determine whether a business shall be certified as a qualifying business and, if applicable, issue written notification to the qualifying business that such business has been certified with the authority for the purpose of issuing investment tax credits. The notice shall indicate that such certification is subject to revocation or expiration pursuant to subrule 115.5(4). The authority will indicate in its written notice the first date investments are eligible for a tax credit based on the date of application for certification and the date the authority expects the certification to expire based on the date the business began operations.

b. The authority will only accept applications for investment tax credits from investors in qualifying businesses that have received a written notice of certification.

115.5(4) Revocation and expiration of certification.

a. A certified qualifying business must notify the authority as soon as it becomes aware of any changes in its eligibility as a qualifying business or in the eligibility of its investors to receive tax credits. A certified qualifying business shall provide any information as the authority may reasonably request to confirm the business's continued eligibility for certification as a qualifying business and the eligibility of its investors to receive tax credits.

b. If a qualifying business fails to meet or maintain any requirement set forth in this chapter, the authority shall revoke the business's certification as a qualifying business by issuing written notification of revocation to the business. If applicable, the notification shall identify the last date on which the business was eligible to be certified as a qualifying business. Investments made after the identified date will not be eligible for a tax credit.

c. If a business continues to satisfy all eligibility requirements until it has been in operations for more than six years, the business's certification will expire on the date identified as the expected date of expiration pursuant to paragraph 115.5(2) "*a.*" Investments made after the identified date will not be eligible for a tax credit.

[ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.6(15E) Approval, issuance and distribution of investment tax credits.

115.6(1) Approval by the board. Upon certification by the authority of a qualifying business and approval of the taxpayer's application, the board will approve the issuance of a tax credit certificate to the taxpayer applying for the tax credit.

115.6(2) Issuance by the authority. Upon approval by the board, the authority shall issue a tax credit certificate to the applicant, provided, however, that such tax credit certificate shall be subject to rescission pursuant to rule 261—115.9(15E).

115.6(3) Preparation of certificate. The tax credit certificate shall be prepared by the authority in a form approved by the board and shall contain the taxpayer's name, address, and tax identification number, the amount of credit, the name of the qualifying business, the year in which the credit may be

redeemed and any other information that may be required by the department of revenue. In addition, the tax credit certificate shall contain the following statement:

Neither the authority nor the board has recommended or approved this investment or passed on the merits or risks of such investment. Investors should rely solely on their own investigation and analysis and seek investment, financial, legal and tax advice before making their own decision regarding investment in this enterprise.

115.6(4) Tax credit amount limitations. The aggregate amount of tax credits issued per fiscal year pursuant to this chapter shall not exceed the amount allocated by the board pursuant to Iowa Code section 15.119.

115.6(5) Waitlist for applications received on or before March 31, 2022.

a. If the maximum aggregate amount of tax credits is awarded in a given fiscal year, investors who are determined eligible for a tax credit but were not awarded a tax credit shall be placed on a waitlist in the order the applications are received. Applications that are placed on a waitlist shall be given priority for receiving tax credits in succeeding fiscal years. Placement on a waitlist pursuant to this paragraph shall not constitute a promise binding the state. The availability of a tax credit and issuance of a tax credit certificate pursuant to this rule in a future fiscal year is contingent upon the availability of tax credits in that particular fiscal year or years. This subrule shall apply only to applications received on or before March 31, 2022.

b. Any application that can be partially approved without exceeding the maximum aggregate amount of tax credits will be approved as to the portion less than the maximum aggregate amount and placed on a waitlist as to the portion greater than the maximum aggregate amount. For example, if an application is eligible for \$50,000 of tax credits, but there is only \$30,000 of the maximum aggregate amount available, the application will be approved for \$30,000 and placed on a waitlist for \$20,000.

115.6(6) Applications received on or after April 1, 2022.

a. Applications for tax credits received on or after April 1, 2022, will not be placed on a waitlist if the maximum aggregate amount of tax credits is awarded in a given fiscal year.

b. Beginning on or after April 1, 2022, the authority will identify an application period, or periods, on the authority's Internet site at www.iowaeda.com for each fiscal year in which an allocation of tax credits is available and has not been fully utilized by applications previously placed on a waitlist pursuant to subrule 115.6(5). Only applications submitted during the established filing window will be reviewed for eligibility by the authority. Each identified application period will remain open until the date indicated by the authority for that fiscal year.

c. Applications received on or after April 1, 2022, in excess of the maximum aggregate amount of tax credits for the fiscal year in which they are received will be denied by the board, regardless of whether the investment was otherwise eligible to receive a tax credit award.

d. Any application that can be partially approved without exceeding the maximum aggregate amount of tax credits will be approved as to the portion less than the maximum aggregate amount and denied as to the portion greater than the maximum aggregate amount. For example, if an application is eligible for \$50,000 of tax credits, but there is only \$30,000 of the maximum aggregate amount available, the application will be approved for \$30,000 and denied for \$20,000.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.7(15E) Claiming the tax credits. To claim a tax credit under this chapter, a taxpayer must include with that taxpayer's tax return a certificate issued pursuant to this chapter when the return is filed with the department of revenue. For more information on claiming tax credits, see department of revenue rules 701—42.22(15E,422), 701—52.21(15E,422), and 701—58.11(15E,422).

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.8(15E) Notification to the department of revenue. Upon the issuance and distribution of investment tax credits for a tax year, the authority shall promptly notify the department of revenue. Such notification shall also include, but not be limited to, the aggregate number and amount of tax credits issued for the tax year.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.9(15E) Rescinding tax credits. In the event that a qualifying business fails to meet or maintain any requirement set forth in this chapter, the authority, upon action by the board, shall rescind any tax credit certificates issued to taxpayers for investments made after the date as of which the business's certification was revoked or expired and shall notify the department of revenue that it has done so. A tax credit certificate that has been rescinded by the authority shall be null and void, and the department of revenue will not accept the tax credit certificate.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 1429C, IAB 4/16/14, effective 5/21/14; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

261—115.10(15E) Additional information—confidentiality—annual report.

115.10(1) Additional information. The authority may at any time request additional information and documentation from a qualifying business regarding the operations, job creation and economic impact of such qualifying business, and the authority may use such information in preparing and publishing any reports to be provided to the governor and the general assembly.

115.10(2) Confidentiality.

a. Except as provided in paragraph “b,” all information or records in the possession of the authority with respect to this chapter shall be presumed by the authority to be a trade secret protected under Iowa Code chapter 550 or common law and shall be kept confidential by the authority unless otherwise ordered by a court.

b. All of the following shall be considered public information under Iowa Code chapter 22:

- (1) The identity of a qualifying business.
- (2) The identity of an investor and the qualifying business in which the investor made an equity investment.
- (3) The number of tax credit certificates issued by the authority.
- (4) The total dollar amount of tax credits issued by the authority.

115.10(3) Annual report. The authority will publish an annual report of the activities conducted pursuant to Iowa Code chapter 15E, division V, and will submit the report to the governor and the general assembly. The report will include a listing of eligible qualifying businesses and the number of tax credit certificates and the amount of tax credits issued by the authority.

[ARC 0009C, IAB 2/8/12, effective 3/14/12; ARC 2541C, IAB 5/25/16, effective 6/29/16; ARC 6242C, IAB 3/9/22, effective 4/13/22]

These rules are intended to implement Iowa Code chapter 15E, subchapter V.

[Filed ARC 0009C (Notice ARC 9845B, IAB 11/16/11), IAB 2/8/12, effective 3/14/12]

[Filed ARC 1429C (Notice ARC 1289C, IAB 1/22/14), IAB 4/16/14, effective 5/21/14]

[Filed ARC 2541C (Notice ARC 2373C, IAB 1/20/16), IAB 5/25/16, effective 6/29/16]

[Filed ARC 6242C (Notice ARC 6140C, IAB 1/12/22), IAB 3/9/22, effective 4/13/22]

CHAPTER 24
PARAEDUCATOR CERTIFICATES
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 22]

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).
[ARC 2230C, IAB 11/11/15, effective 12/16/15]

282—24.2(272) Approved paraeducator certificate programs. An applicant for an initial paraeducator certificate who completes the paraeducator preparation program from a recognized Iowa paraeducator approved program shall have the recommendation from the designated certifying official at the recognized area education agency, local education agency, community college, or institution of higher education where the preparation was completed. A recognized Iowa paraeducator approved program is one which has its program of preparation approved by the state board of education according to standards established by the board of educational examiners.

282—24.3(272) Prekindergarten through grade 12 paraeducator generalist certificate.

24.3(1) Applicants must possess a minimum of a high school diploma or a graduate equivalent diploma.

24.3(2) Qualifications or criteria for the granting or revocation of a certificate or the determination of an individual's professional standing shall not include membership or nonmembership in any teacher or paraeducator organization.

24.3(3) Applicants shall have successfully completed at least 90 clock hours of training in the areas of behavior management, exceptional child and at-risk child behavior, collaboration skills, interpersonal relations skills, child and youth development, technology, and ethical responsibilities and behavior.

24.3(4) Applicants shall have successfully completed the following list of competencies.

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Recognize the different developmental stages of students.
- (2) Believe every student can learn.
- (3) Recognize that each learner has unique learning needs that may require accommodations.
- (4) Demonstrate knowledge of the common core, including competence in reading, writing and math.

(5) Function in a manner that demonstrates a positive regard for the distinction between roles and responsibilities of paraeducators and other professionals, including respecting the teacher as supervisor and seeing the teacher as ultimately responsible for the education and behavior of the students.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will:

(1) Follow the prescribed health, safety, and emergency school and classroom policy and procedures.

- (2) Organize materials to support teaching and learning.
- (3) Facilitate the integration of students with diverse needs in various settings.
- (4) Assist with special health services, under the supervision of a licensed health care provider.
- (5) Promote a safe and positive learning environment.
- (6) Function in various instructional settings (e.g., large group, small group, tutoring).

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Assist with learning activities and opportunities to accomplish instructional objectives.
- (2) Support high expectations that are shared, clearly defined and appropriate.
- (3) Monitor progress and document and report objective observations that inform instructional decisions.
- (4) Effectively use verbal and nonverbal forms of communication with students.
- (5) Assist with the implementation and use of instructional and assistive technology.

d. Emotional and behavioral. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Assist in modeling and teaching specific appropriate behaviors, social skills, and procedures that facilitate safety and learning in various environments.
- (2) Assist in the implementation of individualized behavior management plans.
- (3) Document and report objective observations on student behaviors.
- (4) Assist in modifying the learning environment to manage behavior and social skills.
- (5) Recognize that there is a cause or reason for misbehavior and assist in determining the cause or reason.
- (6) Recognize, address, and report bullying.
- (7) Recognize and report atypical emotional behavior.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Demonstrate a commitment to work as an effective team member.
- (2) Foster a professional and caring relationship with each student's family.
- (3) Develop and maintain positive and professional relationships with students.

f. Ethical and professional practice. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Follow ethical practices for confidential information.
- (2) Participate in ongoing professional development.
- (3) Accept and apply constructive feedback.
- (4) Abide by the Iowa code of ethics and professional practice rules of the board of educational examiners and rules of the Iowa department of education.
- (5) Demonstrate the ability to separate personal issues from one's responsibilities in the workplace.
- (6) Maintain a high level of competency and integrity.
- (7) Share information regarding students' performance, behavior, or program with students' parents or guardians only as directed by the supervising teacher or educator.
- (8) Be aware of personal biases and beliefs and refrain from discriminatory practices based on a student's disability, race, creed, color, religion, age, sex, sexual orientation, gender identity, disability, marital status, or national origin.
- (9) Demonstrate ethical behavior when supporting students with graded activities, quizzes, and tests.
- (10) Abide by Iowa law regarding the use of restraint and seclusion.
- (11) Recognize that the paraeducator may not be given primary responsibility for the education of an individual student(s).
- (12) Recognize that instructional decisions are made by the individualized education program (IEP) team for students with disabilities and that any changes to instruction, accommodations, supports, and services cannot be made outside the IEP team.

24.3(5) An applicant for a certificate under these rules shall demonstrate that the requirements of the certificate have been met, and the burden of proof shall be on the applicant.

[ARC 1325C, IAB 2/19/14, effective 3/26/14]

282—24.4(272) Paraeducator area of concentration. An area of concentration is not required but optional. Applicants must currently hold or have previously held an Iowa paraeducator generalist certificate. Applicants may complete one or more areas of concentration but must complete at least 45 clock hours in each area of concentration, with the exception of the substitute authorization.

24.4(1) Early childhood—prekindergarten through grade 3. The paraeducator shall successfully complete the following list of competencies:

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will:

- (1) Know and understand young children's typical and atypical developmental stages and their needs at each stage.
- (2) Recognize multiple influences on young children's development and learning.

(3) Recognize developmentally appropriate practices for interactions with and the education of young children.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will:

(1) Describe the elements of environments that support children's learning and well-being.

(2) Demonstrate skills, strategies, and activities involving an individual child or small groups of children to reinforce instruction from a licensed teacher.

(3) Set up environments that are safe, inclusive, and responsive to children's developmental strengths, interests and needs.

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

(1) Recognize effective strategies and techniques to stimulate cognitive, physical, social, emotional, and language development for each child in a developmentally appropriate way.

(2) Demonstrate knowledge and understanding of the Iowa Early Learning Standards by describing what young children know and do in order to provide experiences and interactions to promote learning.

(3) Gather information, as instructed by the classroom teacher, about an individual child's development, learning and behaviors including observing, recording, and charting.

d. Emotional and behavioral competencies. Under the supervision of a licensed education professional, the paraeducator will:

(1) Gather information, as instructed by the classroom teacher, to identify children's skills and provide appropriate levels of support needed for the children to access, participate and engage in activities.

(2) Implement teacher-designed intervention plans to promote positive social relationships, interactions and behaviors that are age- and developmentally appropriate.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate the ability to collaborate with an educational team to systematically and regularly exchange information to support problem solving, planning, and the implementing of instruction and individualized interventions.

(2) Demonstrate the ability to establish relationships with all children and their families that are respectful, supportive and sensitive.

(3) Demonstrate a collaborative relationship with the teacher to support children's learning.

(4) Demonstrate knowledge of community services and agencies available to assist families.

f. Ethical and professional practice. Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate knowledge of Iowa Early Learning Standards and the preschool program standards being implemented, which may include the Iowa Quality Preschool Program Standards, Head Start Program Performance Standards and National Association for the Education of Young Children (NAEYC) Program Standards and Accreditation Criteria.

(2) Reserved.

24.4(2) Special needs—prekindergarten through grade 12. The paraeducator shall successfully complete the following list of competencies.

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will demonstrate an understanding of an IEP.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will demonstrate an understanding of the value of serving children and youth with disabilities and special needs in inclusive settings.

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

(1) Implement the activities assigned by a teacher to meet the goals and objectives in an IEP.

(2) Assist in academic subjects through use of lesson plans and instructional strategies developed by teachers and other professional support staff.

(3) Gather and maintain data about the performance of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

(4) Operate computers and use assistive technology and adaptive equipment that will enable students with special needs to participate more fully in general education.

d. Emotional and behavioral. Under the supervision of a licensed education professional, the paraeducator will:

(1) Gather and maintain data about the behavior of individual students and confer with special and general education practitioners about student schedules, instructional goals, progress, and performance.

(2) Use appropriate instructional procedures and reinforcement techniques as specified in the IEP or by the behavior team.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will, if asked, participate as a member of the IEP team responsible for developing service plans and educational objectives.

24.4(3) English as a second language—prekindergarten through grade 12. The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Operate computers and use technology that will enable students to participate effectively in the classroom.

b. Work with the classroom teacher as collaborative partners.

c. Demonstrate knowledge of the role and use of primary language of instruction in accessing English for academic purposes.

d. Demonstrate knowledge of instructional methodologies for second language acquisition.

e. Communicate and work effectively with parents or guardians of English as a second language students in their primary language.

f. Demonstrate knowledge of appropriate translation and interpretation procedures.

24.4(4) Career and transitional programs—grades 5 through 12. The paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified classroom teacher, the paraeducator will be able to:

a. Assist in the implementation of career and transitional programs.

b. Assist in the implementation of appropriate behavior management strategies for career and transitional students and those students who may have special needs.

c. Assist in the implementation of assigned performance and behavior assessments including observation, recording, and charting for career and transitional students and those students who may have special needs.

d. Provide training at job sites using appropriate instructional interventions.

e. Participate in preemployment, employment, or transitional training in classrooms or at off-campus sites.

f. Communicate effectively with employers and employees at work sites and with personnel or members of the public in other transitional learning environments.

24.4(5) School library media—prekindergarten through grade 12. The school library media paraeducator shall successfully complete the following list of competencies so that, under the direct supervision and direction of a qualified school library supervisor or school librarian, the paraeducator will be able to:

a. Be aware of, implement, and support the goals, objectives, and policies of the school library media program.

b. Assist the school library supervisor or school librarian in general operations, such as processing materials, circulating materials, performing clerical tasks, assisting students and staff, and working with volunteers and student helpers, and to understand the role of the paraeducator in the library setting in order to provide efficient, equitable, and effective library services.

c. Demonstrate knowledge of library technical services including, but not limited to, cataloging, processing, acquisitions, routine library maintenance, automation and new technologies.

- d. Be aware of and support the integration of literacy initiatives and content area standards, e.g., visual information and technology in support of the curriculum.
- e. Be aware of the role school libraries play in improving student achievement, literacy, and lifelong learning.
- f. Demonstrate an understanding of ethical issues related to school libraries, such as copyright, plagiarism, privacy, diversity, confidentiality, and freedom of speech.
- g. Assist in the daily operations of the school library program, such as shelving, working with volunteers and student helpers, inventory, materials repair and maintenance.
- h. Exhibit welcoming behaviors to all library patrons and visitors to encourage use of the library and its resources.
- i. Demonstrate knowledge of the school library collection and the availability of other resources that will meet individual student information or research needs.
- j. Demonstrate a general knowledge of basic technology skills and assist in troubleshooting basic hardware and software problems.

24.4(6) *Speech-language pathology (SLP)—prekindergarten through grade 12.* The speech-language pathology paraeducator shall successfully complete the following list of competencies so that, under the direction and supervision of a qualified speech-language pathologist, the paraeducator will be able to:

- a. Understand the roles and responsibilities of the speech-language pathology paraeducator.
- b. Demonstrate a basic understanding of the four areas of communication, including articulation, language, fluency, and voice, and how they occur through typical development.
- c. Demonstrate an understanding of articulation/phonological disabilities.
- d. Demonstrate an understanding of language disabilities.
- e. Use appropriate instructional procedures and reinforcement techniques when working with children with articulation/phonological disabilities.
- f. Use appropriate instructional procedures and reinforcement techniques when working with children with language disabilities.
- g. Gather information as directed by the speech-language pathologist regarding the performance of children, including recording and charting responses.

24.4(7) *Vision impairments—prekindergarten through grade 12.*

- a. Demonstrate knowledge of the impact of vision loss on learning and concept development for students who are blind or visually impaired.
 - (1) Demonstrate introductory knowledge of expanded core curriculum (ECC) and the ability to support ECC skills as directed by the supervising professional.
 - (2) Demonstrate introductory knowledge of functional vision assessments (FVA) and learning media assessments (LMA) of students who have vision impairments.
- b. Demonstrate knowledge of and skills in technology appropriate to the needs of students with vision impairments.
 - (1) Operate and use assistive technology that supports students who have vision impairments.
 - (2) Support and strengthen each student's capability to access and utilize assistive technology.
- c. Demonstrate introductory knowledge of instructional strategies unique to students who have vision impairments.
 - (1) Demonstrate the ability to adapt educational materials by using varied learning media as determined by student needs.
 - (2) Demonstrate an introductory knowledge of Braille in relation to identified or expressed student needs or both.
 - (3) Demonstrate introductory skills in operating transcription software and equipment.
- d. Demonstrate introductory knowledge of motor skills, movement, orientation, and mobility for students with vision impairments.
- e. Demonstrate knowledge of the role of paraeducators in student plans including individualized education programs (IEPs) and individualized family service plans (IFSPs).

f. Demonstrate knowledge about and skills in fostering independence, self-determination, social skills, self-advocacy, and appropriate behaviors for students with vision impairments.

g. Demonstrate professionalism and ethical practices, including appropriate communication skills in relation to students with vision impairments and the students' service providers and families.

24.4(8) Autism spectrum disorders. Under the direction and supervision of a qualified classroom teacher, the paraeducator shall successfully complete the following list of competencies.

a. Foundations. Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate an understanding of the components of education plans (individualized education program (IEP), behavior intervention plan (BIP), functional behavioral analysis (FBA), and Section 504 Plan).

(2) Identify common characteristics of students with autism spectrum disorder (communication, social, restricted interest and behavior) and how these characteristics compare to those of typical children.

b. Learning environment. Under the supervision of a licensed education professional, the paraeducator will:

(1) Assist in structuring the environment to meet the needs of students with autism spectrum disorder.

(2) Implement with integrity schedules and educational programs prescribed by the licensed teacher.

c. Content and instruction. Under the supervision of a licensed education professional, the paraeducator will:

(1) Implement the educational, academic, and communication accommodations, adaptations, and supports assigned by a teacher.

(2) Provide opportunities for students with autism spectrum disorders to initiate and respond to large interactions and small interactions in academic settings.

(3) Provide opportunities for students with autism spectrum disorders to initiate, respond to, and participate in interactions in large groups and small groups in authentic situations.

(4) Gather and maintain data on student academic performance as directed by a licensed teacher.

(5) Assist educational staff in developing accommodations and adaptations and self-determination skills to increase student independence.

d. Emotional and behavioral. Under the supervision of a licensed education professional, the paraeducator will:

(1) Understand and identify the function of a behavior (e.g., antecedents, behaviors, consequences).

(2) Collect data on student behavior and related environmental stimuli, based on the concepts of antecedents, behaviors and consequences.

(3) Implement antecedent strategies on student behavior, as defined by the licensed educator.

(4) Reinforce and practice replacement behaviors, as defined by the licensed educator.

(5) Respond to problem behaviors in a consistent manner, as defined by the licensed educator.

(6) Gather and maintain data on student social and behavioral performance, as directed by a licensed teacher.

e. Professional relationships. Under the supervision of a licensed education professional, the paraeducator will:

(1) Demonstrate the ability to support the viewpoints and perspectives of students with autism and be empathetic to the students' learning styles.

(2) Respond to challenging behaviors in a respectful, empathetic manner.

f. Ethical and professional practice. Under the supervision of a licensed education professional, the paraeducator will:

(1) Know and understand the expectations of confidentiality in regard to student information and social media usage.

(2) Know and understand the legal constructs of the IEP and the Individuals with Disabilities Education Act (IDEA).

24.4(9) Paraeducator substitute authorization. An individual who holds a paraeducator certificate and completes the substitute authorization requirements set forth in rule 282—22.2(272) but who does

not meet the degree requirement in 282—subparagraph 22.2(1)“a”(2) is authorized to substitute only in the special education classroom in which the individual paraeducator is employed, unless emergency permission is granted by the executive director or designee based on documented need provided by the employer.

[ARC 8405B, IAB 12/16/09, effective 1/20/10; ARC 9204B, IAB 11/3/10, effective 12/8/10; ARC 1325C, IAB 2/19/14, effective 3/26/14; ARC 2529C, IAB 5/11/16, effective 6/15/16; ARC 3197C, IAB 7/5/17, effective 8/9/17; ARC 5303C, IAB 12/2/20, effective 1/6/21; see Delay note at end of chapter; ARC 6229C, IAB 3/9/22, effective 2/16/22]

282—24.5(272) Prekindergarten through grade 12 advanced paraeducator certificate. Applicants for the prekindergarten through grade 12 advanced paraeducator certificate shall have met the following requirements:

24.5(1) Currently hold or have previously held an Iowa paraeducator generalist certificate.

24.5(2) Possess an associate’s degree or have earned 62 semester hours of college coursework. Degrees and semester hour credits shall be completed through a college or university accredited by an institutional accrediting agency as recognized by the U.S. Department of Education.

24.5(3) Complete a minimum of 2 semester hours of coursework involving at least 100 clock hours of a supervised practicum with children and youth. These 2 semester hours of practicum may be part of an associate’s degree or part of the earned 62 semester hours of college coursework.

[ARC 5803C, IAB 7/28/21, effective 9/1/21]

282—24.6(272) Renewal requirements.

24.6(1) The paraeducator certificate may be renewed upon application, payment of a renewal fee as established in 282—Chapter 12, and verification of successful completion of coursework totaling three units in any combination listed below.

a. One unit may be earned for each semester hour of credit which leads to the completion of the requirements for an area of concentration not currently held.

b. One unit may be earned for each hour of credit that will assist a paraeducator to demonstrate the knowledge of and the ability to assist in reading, writing, or mathematics.

c. One unit may be earned for each hour of credit completed which supports either the building’s or district’s career development plan.

d. One unit may be earned for each semester hour of college credit.

24.6(2) All applicants renewing a paraeducator certificate must submit documentation of completion of the child and dependent adult abuse trainings pursuant to 282—subrule 20.3(4).

[ARC 4634C, IAB 8/28/19, effective 10/2/19]

282—24.7(272) Issue date on original certificate. A certificate is valid only from and after the date of issuance.

282—24.8(272) Validity. The paraeducator certificate shall be valid for five years.

282—24.9(272) Certificate application fee. All fees are nonrefundable.

24.9(1) *Issuance of certificates.* The fee for the issuance of the paraeducator certificate shall be as established in 282—Chapter 12.

24.9(2) *Adding areas of concentration.* The fee for the addition of each area of concentration to a paraeducator certificate, following the issuance of the initial paraeducator certificate and any area(s) of concentration, shall be as established in 282—Chapter 12.

These rules are intended to implement Iowa Code chapter 272.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]

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[Filed ARC 5803C (Notice ARC 5665C, IAB 6/2/21), IAB 7/28/21, effective 9/1/21]
[Filed Emergency ARC 6229C, IAB 3/9/22, effective 2/16/22]

¹ January 6, 2021, effective date of 24.4 [ARC 5303C, Item 3] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2020.

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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CHAPTER 2
CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES
EMPLOYEES AND PROPERTY

PREAMBLE

In certain circumstances the department of human services has determined it to be permissible to enter into contracts with service providers (contractors) for the use of department employees in a service program or the use of buildings and grounds of state institutions. These rules describe the conditions and processes under which these contractual arrangements will operate and will ensure uniform procedures on all campuses regarding the contracting out of department employees and leasing of state campus buildings and grounds. These rules do not supersede existing policies regarding the sharing of department employees with other state agencies under the authority of the Iowa department of personnel. The department shall implement procedures consistently.

441—2.1(23A,225C) Definitions.

“*Contract manager*” is the person identified within the department of human services, division of administration, who will act as the central point of contact regarding all use and leasing of state institution buildings and grounds.

“*Contractor*” means a nonprofit entity as defined by Iowa Code chapter 504A that purchases the services of the department, including department employees, to be used to supplement its own service provision.

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

“*Division*” includes the divisions of mental health and disability services; and adult, children and family services.

“*Lessee*” means a nonprofit provider of services or other approved activity or other nonprofit entity as defined by Iowa Code chapter 504A that has been permitted to lease space in certain buildings or grounds on one or more of the mental health institutes, state resource centers, the state training school at Eldora, Iowa, or the civil commitment unit for sexual offenders at Cherokee, Iowa, from the department.

“*State institutions*” (also referred to as campuses), for the purposes of this chapter, include: the Glenwood and Woodward state resource centers; the Cherokee and Independence mental health institutions; the state training school in Eldora; and the civil commitment unit for sexual offenders in Cherokee.

“*Superintendents*” are the administrators of these state institutions as defined by Iowa Code chapter 218 as well as those administrators appointed by the director of the department of human services pursuant to Iowa Code chapter 233A at the state training school in Eldora.

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441—2.2(23A,225C) Contracts for use of the services of department employees. All determinations regarding whether the department shall enter into a contract for services shall be made by the director of the department or designee. All determinations are considered final and binding and are not subject to appeal. The director of the department or designee shall weigh the following criteria in making the decision.

2.2(1) Expertise. Department employees shall possess certain expertise and skills needed by a contractor.

2.2(2) Mutual benefit. There shall be a mutual benefit to the department and the contractor.

2.2(3) Payment. Payment for the full cost, both direct and indirect, of department employees shall be received from the contractor.

2.2(4) Supplementation of services. The intent of the department is to permit its employees to provide services to on-campus lessees. Department employees may supplement the direct service provided by the contractor, but department employees shall not assume full responsibility for the care and treatment of consumers of services of the contractor.

2.2(5) *Use of department employees.* Department employees shall not be used to fill vacancies of full-time staff positions of the contractor, nor can the full time of a single department employee be contracted to a single contractor. For time-limited periods, and when it is in the best interest of the state, a state institution, with approval of the director of the department and the director of the Iowa department of personnel, may contract to provide department employees to a contractor on a full-time basis.

2.2(6) *Nonprofit status.* Department employees shall only be contracted out to nonprofit entities as defined by Iowa Code chapter 504A.

2.2(7) *Conflict of interest.* A contract shall not be entered into if it creates a conflict of interest as defined by Iowa and federal law for either the department employees, the department in general, the state of Iowa, or the contractor.

2.2(8) *Services to department clients.* Department employees' time shall be made available to a potential contractor only if it can be done without harm to the department's institution clients who are receiving services on an inpatient or outpatient basis.

2.2(9) *Subcontracting.* The department shall not subcontract out the time or services of a person under contract to the department. Persons who perform services as independent contractors to the state of Iowa, pursuant to a personal services contract, shall not be included in any agreement entered into pursuant to this chapter. However, this does not prohibit an independent contractor from directly entering into a contractual relationship with a contractor.

441—2.3(23A,225C) Contract provisions. A contract for service entered into pursuant to this chapter shall include the following provisions, plus other provisions as determined by the director of the department or designee:

2.3(1) *Rate setting.* All contract rates will be set by the department. The contract shall cover the full costs of the department including, but not limited to, any base salary or wage, vacation, applicable leave, and other fringe benefits paid for by the state of Iowa at the time of the contract and any subsequent increases.

2.3(2) *Collective bargaining agreements.* If the department employees to be included in the contract are covered by a collective bargaining agreement, the contractor shall be bound by the applicable collective bargaining agreement. The contractor shall further agree that any decision relative to the collective bargaining agreement between the department and its employees shall be binding on the contractor. Should any provision of the agreement between the parties be found to violate the terms and conditions of an applicable collective bargaining agreement, the provision or condition contained in the agreement entered into pursuant to this chapter shall be void.

2.3(3) *Conditions of employment.* The contract shall not impose any conditions of employment outside of those conditions of employment currently imposed by the state of Iowa.

2.3(4) *Liability.* The contractor agrees to defend, indemnify, and hold harmless the state and the department against all claims, damages, losses, costs, and expenses, including attorney fees, arising out of any services performed pursuant to an agreement entered into under this chapter.

2.3(5) *Private contracting.* A department employee covered by an agreement entered into pursuant to this chapter shall be prohibited from contracting privately with the same contractor.

2.3(6) *Conditions.* All contracts must comply with conditions and negotiations mutually agreed upon by the department and the Iowa department of personnel.

2.3(7) *Term of contract.* Contracts shall be for a specific term and shall be cosigned by the department and the Iowa department of personnel on behalf of the state of Iowa and by the contractor.

2.3(8) *Copies of contract.* Copies of the contract shall be maintained by the respective division, the business office of the respective campus, and the contractor.

2.3(9) *Program name.* Without the prior written approval of the director, the entity seeking to contract with the state shall not use or cause to be used a name for the program or project that is in any way similar to the name or part of the name of the institution.

441—2.4(23A,225C) Leasing of space at state institutions. All determinations regarding leasing space at state institutions shall be made by the director of the department or designee. All determinations are

considered final and binding and are not appealable. The director of the department or designee shall weigh the following criteria in making the determination.

2.4(1) Available space. Space shall be available on one or more of the campuses.

2.4(2) Activities. Lessees may not engage in activities that will interfere with, impede, or conflict with the basic treatment, habilitation, or care programs operated on the campuses by the department. Lessees may not engage in activities that will endanger or otherwise threaten the safety and well-being of department consumers of services, the community at large, or department employees.

2.4(3) Nonprofit status. Lessees must be public or private nonprofit entities as defined by Iowa Code chapter 504A and must provide documentation of nonprofit status upon request of the department.

2.4(4) Needs and priorities. Needs of the residents of Iowa shall be considered before needs of the residents of other states. Needs shall be prioritized as follows:

a. Needs of the department other than current occupancy and use.

b. Needs of other state or local governmental bodies for human or social service related purposes that benefit Iowans before citizens of other states.

c. Needs of other state or local governmental bodies for other than human or social service related purposes.

d. Needs of private, nonprofit entities for human or social service related purposes.

e. Needs of private, nonprofit entities for other than human or social service related purposes that are determined to be compatible uses of state institution buildings and grounds.

2.4(5) Services. Lessees must use the leased premises to provide disability services or other services normally delivered by the lessee.

441—2.5(23A,225C) Requirements prior to leasing. The following shall be required prior to the leasing of campus buildings or grounds.

2.5(1) Referral to contract manager. A campus superintendent or designee may show available space to a potential lessee but has no authority to approve any leasing arrangements or to commit buildings or grounds to potential lessees. Superintendents shall notify the contract manager if contacted by a potential lessee. If space is available or expected to be available on the campus, the superintendent shall direct all entities interested in pursuing lease arrangements to contact the contract manager in the department's central office.

2.5(2) Written proposal. The potential lessee shall submit a written program proposal to the contract manager that contains, at a minimum, the following information:

a. A brief history and description of the business operations of the potential lessee, including documentation of nonprofit status if needed.

b. Details regarding the proposed usage of the leased space or grounds.

c. If the proposal is to lease space for office use, the information submitted shall include the type of business to be conducted in the leased space, the proposed number of employees to be housed in the space, the expected hours of operation, and the numbers and types of persons expected to use the office for business purposes.

d. If the proposal is to provide either residential or nonresidential treatment, habilitation, care or educational services in the leased space, the information submitted shall include a detailed program description specifying the age, numbers and types of persons to be served, the habilitation or treatment modalities to be used, including the guidelines for admission to service, and the anticipated referral sources (e.g., other institutions, courts, persons from Iowa or other states).

e. If the proposal is to provide either residential or nonresidential treatment, habilitation, care or educational services, written documentation of all applicable approvals, certifications, accreditations, or licenses that authorize the potential lessee to provide the proposed service shall be submitted. Failure to obtain or maintain legally required approvals, certifications, accreditations, or licenses shall prevent the development of or cause the termination of lease agreements. Temporary leasing arrangements may be considered if deemed necessary in order for the lessee to receive the needed documentation per the above.

f. A description of the potential lessees' service and support expectations of the department such as whether department employees will be needed to assist the program and what arrangements the lessee intends to make for services such as janitorial, laundry, and food services.

g. Identification of proposed renovations that will be needed in order for the lessee to carry out its proposed activities. The lessee shall propose how and by whom the renovations would be completed. The lessee shall be responsible for the full cost involved in all renovations, and all renovations must comply with applicable federal, state, and local requirements including, but not limited to, the Americans with Disabilities Act, and health, safety, and fire codes.

h. Verification of terms and conditions that allow the department to have a cost-neutral lease (rent must cover expenses).

i. Other information deemed necessary by the contract manager.

2.5(3) *Evaluation of proposals.* The contract manager, in collaboration with the respective division administrator and the respective superintendents, shall evaluate all proposals to determine if they meet the general principles identified above. The division administrator, in collaboration with the respective superintendent(s), shall recommend whether to proceed with the leasing process to the director or designee. The contract manager shall notify the potential lessee in writing of the director's or designee's decision and, if applicable, identify the reasons for denial. All decisions are considered final and binding and are not subject to appeal.

2.5(4) *Indemnity and insurance.* All contracts shall include clauses that address the following:

a. All contractors shall indemnify, hold harmless and defend the state, the department, and its officers and employees from and against all suits, actions, or claims for personal injury or death, or damage to property because of any act, omission or neglect of the contractor, its officers, agents or employees in the provision of services or other activities as provided for by administrative rule and contracts developed pursuant to this chapter, including, but not limited to:

(1) Personal injury, death or property damage of a client receiving care or services, or while on a premises owned, leased or operated by the contractor, or while being transported by the provider, either directly or by arrangement.

(2) Personal injury, death or property damage of another caused by a client while receiving care or services from the contractor.

This provision does not create any right or cause of action in the public or a third party to bring a claim or suit under or pursuant to its terms.

b. The contractor agrees that it shall have in force and effect a liability insurance policy covering all its operations in providing the care and services required by the administrative rules and by contract, including the indemnity provision above. A "Certificate of Insurance" identifying the insurance company, the policy period, the type of policy and the limits of coverage shall be filed with the department. The insurance policy and the certificate of insurance shall show the state of Iowa and the department of human services as additional named insured. The contractor further agrees that anyone transporting, or authorized to transport, clients in privately owned vehicles shall have liability insurance in force and effect covering any claim which may arise from this transport.

2.5(5) *Request for proposal.* When only one party is expressing interest in leasing space, the department, before entering into a lease agreement, shall review the proposal and determine whether the proposal and use of the space requires the department to publish a request for proposal in lieu of executing a lease between the parties. If it is determined that publishing a request for proposal is needed, the proposed lessee can then respond to the request for proposal.

2.5(6) *Program name.* Without the prior written approval of the director, the entity seeking to contract with the state shall not use or cause to be used a name for the program or project that is in any way similar to the name or part of the name of the institution.

[ARC 6223C, IAB 3/9/22, effective 5/1/22]

These rules are intended to implement Iowa Code sections 23A.2 and 225C.13.

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CHAPTER 25
DISABILITY SERVICES MANAGEMENT

PREAMBLE

This chapter provides for definitions of regional core services; access standards; implementation dates; practice standards; reporting of regional expenditures; development and submission of regional management plans; data collection; applications for funding as they relate to regional service systems for adults with mental illness, intellectual disabilities, developmental disabilities, or brain injury and children with a serious emotional disturbance.

[ARC 0576C, IAB 2/6/13, effective 1/8/13; ARC 0735C, IAB 5/15/13, effective 8/1/13; ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 1671C, IAB 10/15/14, effective 9/25/14; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

DIVISION I
REGIONAL SERVICES

441—25.1(331) Definitions.

“*Access center*” means the coordinated provision of intake assessment, screening for multi-occurring conditions, care coordination, crisis stabilization residential services, subacute mental health services, and substance abuse treatment for individuals experiencing a mental health or substance use crisis who do not need inpatient psychiatric hospital treatment, but who do need significant amounts of supports and services not available in other home- and community-based settings.

“*Adult*” means the same as defined in 441—subrule 78.27(1).

“*Assertive community treatment*” or “*ACT*” means a program of comprehensive outpatient services consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration, provided in the community and directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of individuals with severe and persistent mental illness and individuals with complex symptomology who require multiple mental health and supportive services to live in the community.

“*Assessment and evaluation*” means the clinical review by a mental health professional of the current functioning of the individual using the service in regard to the individual’s situation, needs, strengths, abilities, desires and goals to determine the appropriate level of care.

“*Behavioral health inpatient treatment*” or “*mental health inpatient treatment*” means inpatient psychiatric services to treat an acute psychiatric condition provided in a licensed hospital with a psychiatric unit or a licensed freestanding psychiatric hospital.

“*Behavioral health outpatient therapy*” means the same as “outpatient services” described in Iowa Code section 230A.106(2)“a.”

“*Brain injury*” means the same as defined in rule 441—83.81(249A).

“*Care coordination*” means facilitating communication and ensuring provision of services among multiple professionals and service providers, the individual, and family members or other natural supports when designated by the individual, and ensuring the individual has the information necessary to actively participate in service and discharge or transition planning.

“*Case management*” means service provided by a case manager who assists individuals in gaining access to needed medical, social, educational, and other services through assessment, development of a care plan, referral, monitoring and follow-up using a strengths-based service approach that helps individuals achieve specific desired outcomes leading to a healthy self-reliance and interdependence with their community.

“*Case manager*” means a person who has completed specified and required training to provide case management through the medical assistance program.

“*Child*” or “*children*” means a person or persons under 18 years of age.

“*Children’s behavioral health services*” means behavioral health services for children who have a diagnosis of serious emotional disturbance.

“Children’s behavioral health system” or *“children’s system”* means the behavioral health system for children implemented pursuant to Iowa Code chapter 225C.

“Community-based crisis intervention service” means a program designed to stabilize an acute crisis episode and to restore an individual and family to their pre-crisis level of functioning. Crisis services are available 24 hours a day, 365 days a year, including telephone and walk-in crisis service and crisis care coordination.

“Comprehensive assessment” means the same as “crisis assessment” defined in rule 441—24.20(225C) for individuals being referred to crisis stabilization residential services and means the same as “assessment” defined in rule 481—71.2(135G) for individuals being referred to subacute mental health services.

“Crisis assessment” means the same as defined in rule 441—24.20(225C).

“Crisis care coordination” means a service provided during an acute crisis episode that facilitates working together to organize a plan and service transition programming, including working agreements with inpatient behavioral health units and other community programs. The service shall include referrals to mental health services and other supports necessary to maintain community-based living capacity, including case management as defined herein.

“Crisis evaluation” means the process used with an individual to collect information related to the individual’s history and needs, strengths, and abilities in order to determine appropriate services or referral during an acute crisis episode.

“Crisis intervention plan” means the same as defined in rule 441—24.1(225C).

“Crisis screening” means a brief assessment to make a determination of the presenting problem and referral to the appropriate level of care.

“Crisis stabilization community-based services” or *“CSCBS”* means the same as defined in rule 441—24.20(225C).

“Crisis stabilization residential services” or *“CSRS”* means the same as defined in rule 441—24.20(225C).

“Day habilitation” means services that assist or support the individual in developing or maintaining life skills and community integration. Services shall enable or enhance the individual’s functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

“Early identification” means the process of detecting developmental delays, mental illness, or untreated conditions that may indicate the need for further evaluation.

“Early intervention” means services designed to address the social, emotional, and developmental needs of children at their earliest stages to decrease long-term effects and provide support in meeting developmental milestones.

“Education services” means activities that increase awareness and understanding of the causes and nature of conditions or factors which affect an individual’s development and functioning.

“Emergency care” means the same as defined in rule 441—88.21(249A).

“Emergency detention” means the same as “immediately detained” as described in Iowa Code section 229.22(1).

“Evidence-based services” means using interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial and effective and have established standards for fidelity of the practice.

“Face-to-face” means the same as defined in rule 441—24.20(225C).

“Family psychoeducation” means services including the provision of emotional support, education, resources during periods of crisis, and problem-solving skills consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“Family support” means services provided by a family support peer specialist that assist the family of an individual to live successfully in the family or community including, but not limited to, education and information, individual advocacy, family support groups, and crisis response.

“Family support peer specialist” means a parent, primary caregiver, foster parent or family member of an individual who has successfully completed standardized training to provide family support through the medical assistance program or the Iowa Behavioral Health Care Plan.

“Group supported employment” means the job and training activities in business and industry settings for groups of no more than eight workers with disabilities. Group settings include enclaves, mobile crews, and other business-based workgroups employing small groups of workers with disabilities in integrated, sustained, paid employment.

“HCBS” means home- and community-based services as defined in rule 441—78.27(249A).

“Health homes” means a service model that facilitates access to an interdisciplinary array of medical care, behavioral health care, and community-based social services and supports for both children and adults with chronic conditions. Services may include comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.

“Home and vehicle modification” means a service that provides physical modifications to the home or vehicle that directly address the medical health or remedial needs of the individual and that are necessary to provide for the health, welfare, and safety of the individual and to increase or maintain independence.

“Home health aide services” means unskilled medical services which provide direct personal care. This service may include assistance with activities of daily living, such as helping the recipient to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician.

“Homeless” means the same as “homeless person” defined in rule 441—25.11(331).

“Illness management and recovery” means a broad set of strategies designed to help individuals with serious mental illness collaborate with professionals, reduce the individuals’ susceptibility to the illness, and cope effectively with the individuals’ symptoms consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“Individual” means any person seeking or receiving services in a regional service system.

“Individual supported employment” means services including ongoing supports needed by an individual to acquire and maintain a job in the integrated workforce at or above the state’s minimum wage. The outcome of this service is sustained paid employment that meets personal and career goals.

“Intake assessment” means the process used with an individual to collect information related to the individual’s history, needs, strengths, and abilities for the purpose of determining the individual’s need for comprehensive assessment, appropriate services or referral.

“Integrated treatment for co-occurring substance abuse and mental health disorders” means effective dual diagnosis programs that combine mental health and substance abuse interventions tailored for the complex needs of individuals with co-morbid disorders. Critical components of effective programs include a comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interviews; provision of help to individuals in acquiring skills and supports to manage both illnesses and pursue functional goals with cultural sensitivity and competence consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“Intensive residential service homes” or *“intensive residential services”* means intensive, community-based services provided 24 hours a day, 7 days a week, 365 days a year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in subrule 25.6(8).

“Job development” means services that assist individuals in preparing for, securing and maintaining gainful, competitive employment. Employment shall be integrated into normalized work settings, shall provide pay of at least minimum wage, and shall be based on the individual’s skills, preferences,

abilities, and talents. Services assist individuals seeking employment to develop or re-establish skills, attitudes, personal characteristics, interpersonal skills, work behaviors, and functional capacities to achieve positive employment outcomes.

“Medical assistance program” means the same as defined in Iowa Code section 249A.2.

“Medication management” means services provided directly to or on behalf of the individual by a licensed professional as authorized by Iowa law including, but not limited to, monitoring effectiveness of and compliance with a medication regimen; coordination with care providers; investigating potentially negative or unintended psychopharmacologic or medical interactions; reviewing laboratory reports; and activities pursuant to licensed prescriber orders.

“Medication prescribing” means services with the individual present provided by an appropriately licensed professional as authorized by Iowa law including, but not limited to, determining how the medication is affecting the individual; determining any drug interactions or adverse drug effects on the individual; determining the proper dosage level; and prescribing medication for the individual for the period of time before the individual is seen again.

“Mental health inpatient treatment” or *“behavioral health inpatient treatment”* means inpatient psychiatric services to treat an acute psychiatric condition that are provided in a licensed hospital with a psychiatric unit or a licensed freestanding psychiatric hospital.

“Mental health outpatient therapy” means the same as defined in Iowa Code section 230A.106(2) “a.”

“Mental health professional” means the same as defined in Iowa Code section 228.1(6).

“Mobile response” means the same as defined in rule 441—24.20(225C).

“Multi-occurring conditions” means a diagnosis of a severe and persistent mental illness occurring along with one or more of the following: a physical health condition, a substance use disorder, an intellectual or developmental disability, or a brain injury.

“No reject, no eject” means that an individual who otherwise meets the eligibility criteria for a service shall not be denied access to that service or discharged from that service based on the severity or complexity of that individual’s mental health and multi-occurring needs.

“Peer support services” means a program provided by a peer support specialist including but not limited to education and information, individual advocacy, family support groups, crisis response, and respite to assist individuals in achieving stability in the community.

“Peer support specialist” means an individual who has experienced a severe and persistent mental illness and who has successfully completed standardized training to provide peer support services through the medical assistance program or the Iowa Behavioral Health Care Plan.

“Permanent supportive housing” means voluntary, flexible supports to help individuals with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Tenants have access to an array of services that help them keep their housing, such as case management, assistance with daily activities, conflict resolution, and crisis response consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“Personal emergency response system” means an electronic device connected to a 24-hour staffed system which allows the individual to access assistance in the event of an emergency.

“Precariously housed” means that a person does not have a permanent household and is living day-to-day in a motel, in a vehicle, with family or friends, or in some other temporary location.

“Prescreening assessment” means a face-to-face clinical interview to ascertain an individual’s current and previous level of functioning, potential for dangerousness, physical health, and psychiatric and medical condition.

“Prevention” means efforts to increase awareness and understanding of the causes and nature of conditions or situations which affect an individual’s functioning in society. Prevention activities are designed to convey information about the cause of conditions, situations, or problems that interfere with an individual’s functioning or ways in which that information can be used to prevent their occurrence or reduce their effect and may include, but are not limited to, training events, webinars, presentations, and public meetings.

“Prevocational services” means services that focus on developing generalized skills that prepare an individual for employment. Prevocational training topics include but are not limited to attendance, safety skills, following directions, and staying on task.

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

“Region” means a mental health and disability service region that operates as the “regional administrator” or “regional administrative entity” as defined in rule 441—25.11(331).

“Respite services” means a temporary period of relief and support for individuals and their families provided in a variety of settings. The intent is to provide a safe environment with staff assistance for individuals who lack an adequate support system to address current issues related to a disability. Respite may be provided for a defined period of time; respite is either planned or provided in response to a crisis.

“Routine care” means the same as defined in rule 441—88.21(249A).

“Rural” means any area that is not defined as urban.

“Serious emotional disturbance” means the same as defined in Iowa Code section 225C.2.

“Severe and persistent mental illness” or *“SPMI”* means a documented primary mental health disorder diagnosed by a mental health professional that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning inclusive of social, personal, family, educational or vocational roles. The individual has a degree of impairment arising from a psychiatric disorder such that: (1) the individual does not have the resources or skills necessary to maintain function in the home or community environment without assistance or support; (2) the individual’s judgment, impulse control, or cognitive perceptual abilities are compromised; (3) the individual exhibits significant impairment in social, interpersonal, or familial functioning; and (4) the individual has a documented mental health diagnosis. For this purpose, a “mental health diagnosis” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance use disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

“State board” means the children’s behavioral health system state board created in Iowa Code section 225C.51.

“Strengths-based case management” means a service that focuses on possibilities rather than problems and strives to identify and develop strengths to assist individuals reach their goals leading to a healthy self-reliance and interdependence with their community. Identifiable strengths and resources include family, cultural, spiritual, and other types of social and community-based assets and networks.

“Subacute mental health services” means the same as defined in Iowa Code section 225C.6(4) “c” and includes both subacute facility-based services and subacute community-based services.

“Substance use disorder” means the same as defined in rule 641—155.1(125,135).

“Supported community living services” means services as defined in Iowa Code section 225C.21(1).

“Supported employment” means an approach to helping individuals participate as much as possible in competitive work in integrated work settings that are consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals. Services are targeted for individuals with significant disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability including either individual or group supported employment, or both, consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration.

“Telephone crisis service” means a program that operates a crisis hotline either directly or through a contract. The service shall be available 24 hours a day and seven days a week including, but not limited to, relief of distress in pre-crisis and crisis situations, reduction of the risk of escalation, arrangements for emergency on-site responses when necessary, and referral of callers to appropriate services.

“*Trauma-focused services*” means services provided by caregivers and professionals that recognize when an individual who has been exposed to violence is in need of help to recover from adverse impacts; recognize and understand the impact that exposure to violence has on victims’ physical, psychological, and psychosocial development and well-being; and respond by helping in ways that reflect awareness of adverse impacts and consistently support the individual’s recovery.

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

“*Trauma-specific treatment*” means services provided by a mental health professional using therapies that are free from the use of coercion, restraints, seclusion and isolation; and designed specifically to promote recovery from the adverse impacts of violence exposure on physical, psychological, psychosocial development, health and well-being.

“*Twenty-four-hour crisis response*” means the same as defined in rule 441—24.20(225C).

“*Twenty-three-hour observation and holding*” means the same as defined in rule 441—24.20(225C).

“*Urban*” means a county that has a total population of 50,000 or more residents or includes a city with a population of 20,000 or more.

“*Urgent nonemergency need*” means the same as defined in rule 441—88.21(249A).

“*Walk-in crisis service*” means a program that provides unscheduled face-to-face support and intervention at an identified location or locations. The service may be provided directly by the program or through a contract with another mental health provider.

“*Warm handoff*” means an approach to care transitions in which a health care provider uses face-to-face or telephone contact to directly link individuals being treated to other providers or specialists.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.2(331) Core service domains.

25.2(1) The region shall ensure that core service domains are available in regions as determined in Iowa Code sections 331.397 and 331.397A.

25.2(2) The region shall include and respect the recommendation of the individual and the individual’s care team in the process of transition to new services.

25.2(3) The region shall ensure that the following services are available for adults in the region:

- a. Access centers.
- b. Assertive community treatment.
- c. Assessment and evaluation.
- d. Case management.
- e. Crisis evaluation.
- f. Crisis stabilization community-based services.
- g. Crisis stabilization residential services.
- h. Day habilitation.
- i. Family support.
- j. Health homes.
- k. Home and vehicle modification.
- l. Home health aide.
- m. Intensive residential service homes.
- n. Job development.
- o. Medication prescribing and management.
- p. Mental health inpatient treatment.
- q. Mental health outpatient treatment.
- r. Mobile response.
- s. Peer support.

- t. Personal emergency response system.
- u. Prevocational services.
- v. Respite.
- w. Subacute mental health services.
- x. Supported employment.
- y. Supportive community living.
- z. Twenty-four-hour access to crisis response.
- aa. Twenty-three-hour crisis observation and holding.

Regions may fund or provide other services in addition to the required core services consistent with requirements set forth in subrules 25.2(5) and 25.2(6).

25.2(4) The region shall ensure that the following services are available for children in the region:

- a. Assessment and evaluation relating to eligibility for services.
- b. Behavioral health inpatient treatment.
- c. Behavioral health outpatient therapy.
- d. Crisis stabilization community-based services.
- e. Crisis stabilization residential services.
- f. Early identification.
- g. Early intervention.
- h. Education services.
- i. Medication prescribing and management.
- j. Mobile response.
- k. Prevention.

25.2(5) A regional service system shall consider the scope of services included in addition to the required core services. Each service included shall be described and projection of need and the funding necessary to meet the need shall be included.

25.2(6) A regional service system may provide funding for other appropriate services or support. In considering whether to provide such funding, a region may consider the following criteria:

- a. Applying a person-centered planning process to identify the need for the services or other support.
- b. The efficacy of the services or other support is recognized as an evidence-based practice, is deemed to be an emerging and promising practice, or providing the services is part of a demonstration and will supply evidence as to the effectiveness of the services.
- c. A determination that the services or other support provides an effective alternative to existing services that have been shown by the evidence base to be ineffective, to not yield the desired outcome, or to not support the principles outlined in *Olmstead v. L.C.*, 527 U.S. 581.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.3(331) Implementation dates.

25.3(1) Regions shall implement the following core services effective July 1, 2014:

- a. Assessment and evaluation.
- b. Case management.
- c. Crisis evaluation.
- d. Day habilitation.
- e. Family support.
- f. Health homes.
- g. Home and vehicle modification.
- h. Home health aide.
- i. Job development.
- j. Medication prescribing and management.
- k. Mental health inpatient therapy.
- l. Mental health outpatient therapy.

- m.* Peer support.
- n.* Personal emergency response system.
- o.* Prevocational services.
- p.* Respite.
- q.* Supported employment.
- r.* Supportive community living.
- s.* Twenty-four-hour access to crisis response.

25.3(2) Regions shall implement the following intensive mental health core services on or before July 1, 2021, provided that federal matching funds are available under the Iowa health and wellness plan pursuant to Iowa Code chapter 249N:

- a.* Access centers.
- b.* Assertive community treatment.
- c.* Crisis stabilization community-based services.
- d.* Crisis stabilization residential services.
- e.* Intensive residential service homes.
- f.* Mobile response.
- g.* Subacute mental health services provided in facility and community-based settings.
- h.* Twenty-three-hour crisis observation and holding.

25.3(3) Regions shall implement the following children's behavioral health core services on or before July 1, 2020, and meet applicable access standards on or before July 1, 2021:

- a.* Assessment and evaluation relating to eligibility for services.
- b.* Behavioral health outpatient therapy.
- c.* Education services.
- d.* Medication prescribing and management.
- e.* Prevention.

25.3(4) Regions shall implement the following children's behavioral health core services on or before July 1, 2021, and meet applicable access standards on or before July 1, 2021:

- a.* Behavioral health inpatient treatment.
- b.* Crisis stabilization community-based services.
- c.* Crisis stabilization residential services.
- d.* Early identification.
- e.* Early intervention.
- f.* Mobile response.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.4(331) Access standards. Regions shall meet the following access standards:

25.4(1) A sufficient provider network which shall include:

- a.* A community mental health center or federally qualified health center that provides psychiatric and outpatient mental health services to individuals in the region.
- b.* A hospital with an inpatient psychiatric unit or state mental health institute located in or within reasonably close proximity that has the capacity to provide inpatient services.

25.4(2) Crisis services shall be available 24 hours per day, 7 days per week, 365 days per year for individuals experiencing mental health and disability-related emergencies. A region may make arrangements with one or more other regions to meet the required access standards.

a. Basic crisis response.

(1) Twenty-four-hour crisis response. An individual shall have immediate access to crisis response services by means of telephone, electronic, or face-to-face communication.

(2) Crisis evaluation. An individual shall have immediate access to a crisis screening and will have a crisis assessment by a licensed mental health professional within 24 hours of referral.

b. Crisis stabilization community-based services. An individual who has been determined to need CSCBS shall receive face-to-face contact from the CSCBS provider within 120 minutes from the time of referral.

c. Crisis stabilization residential services. An individual who has been determined to need CSRS shall receive CSRS within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

d. Mobile response. An individual in need of mobile response services shall have face-to-face contact with mobile crisis staff within 60 minutes of dispatch.

e. Twenty-three-hour observation and holding. An adult who has been determined to need 23-hour observation and holding shall receive 23-hour observation and holding within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

25.4(3) The region shall provide the following treatment services:

a. Outpatient.

(1) Emergency: During an emergency, outpatient services shall be initiated to an individual within 15 minutes of telephone contact.

(2) Urgent: Outpatient services shall be provided to an individual within one hour of presentation or 24 hours of telephone contact.

(3) Routine: Outpatient services shall be provided to an individual within four weeks of request for appointment.

(4) Distance: Outpatient services shall be offered within 30 miles for an individual residing in an urban community and 45 miles for an individual residing in a rural community.

b. Inpatient.

(1) An individual in need of emergency inpatient services shall receive treatment within 24 hours.

(2) Inpatient services shall be available within reasonably close proximity to the region.

c. Assessment and evaluation. An individual who has received inpatient services shall be assessed and evaluated within four weeks.

25.4(4) Subacute facility-based mental health services. An adult shall receive subacute facility-based mental health services within 24 hours of referral. The service shall be located within 120 miles of the residence of the individual.

25.4(5) Support for community living for adults. The first appointment shall occur within four weeks of the individual's request of support for community living.

25.4(6) Support for employment for adults. The initial referral shall take place within 60 days of the individual's request of support for employment.

25.4(7) Recovery services for adults. An individual receiving recovery services shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

25.4(8) Service coordination.

a. An adult receiving service coordination shall not have to travel more than 30 miles if residing in an urban area or 45 miles if residing in a rural area to receive services.

b. An adult shall receive service coordination within ten days of the initial request for such service or being discharged from an inpatient facility.

25.4(9) The region shall make the following intensive mental health services available for adults. A region may make arrangements with one or more other regions to meet the required access standards.

a. Assertive community treatment.

(1) A minimum of 22 ACT teams shall be operational statewide.

(2) A sufficient number of ACT teams shall be available to serve the number of individuals in the region who are eligible for ACT services. As a guideline for planning purposes, the ACT-eligible population is estimated to be about 0.06 percent of the adult population of the region. The region may identify multiple geographic areas within the region for ACT team coverage. Regions may work with one or more other regions to identify geographic areas for ACT team coverage.

b. Access centers.

(1) A minimum of six access centers shall be operational statewide.

(2) An access center shall be located within 120 miles of the residence of the individual or be available within 120 minutes from the time of the determination that the individual needs access center services.

c. Intensive residential services.

(1) A minimum of 120 intensive residential service beds shall be available statewide.

(2) An individual receiving intensive residential services shall have the service available within two hours of the individual's residence.

(3) An individual shall be admitted to intensive residential services within four weeks from referral.

25.4(10) The following limitations apply to home and vehicle modification for an individual receiving mental health and disability services:

a. A lifetime limit equal to that established for the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

b. A provider reimbursement payment will be no lower than that provided through the home- and community-based services waiver for individuals with intellectual disabilities in the medical assistance program.

25.4(11) The region shall make the following efforts and activities related to children's behavioral health available to the residents of the region:

a. Prevention. Prevention activities shall be carried out at least four times a year.

b. Education services. Education activities shall be carried out at least four times a year.

25.4(12) The region shall ensure that the following behavioral health services are available to children in the region:

a. Early identification. A child shall receive early identification services within four weeks of the time the request for such services is made.

b. Early intervention. A child shall receive early intervention services within four weeks of the time the request for such services is made.

[ARC 1096C, IAB 10/16/13, effective 11/20/13; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.5(331) Practices. A region shall ensure that access is available to providers of core services that demonstrate the following competencies:

25.5(1) Regions shall have service providers that are trained to provide effective services to individuals with multi-occurring conditions. Training for serving individuals with multi-occurring conditions provided by the region shall be training identified by the Substance Abuse and Mental Health Services Administration, the Dartmouth Psychiatric Research Center or other generally recognized professional organization specified in the regional service system management plan.

25.5(2) Regions shall have service providers that are trained to provide effective trauma-informed care. Trauma-informed care training provided by the region shall be recognized by the National Center for Trauma-Informed Care or other generally recognized professional organization specified in the regional service system management plan.

25.5(3) Regions must have evidence-based practices that the region has independently verified as meeting established fidelity to evidence-based service models including, but not limited to, assertive community treatment or strengths-based case management; integrated treatment of co-occurring substance use and mental health disorders; supported employment; family psychoeducation; illness management and recovery; and permanent supportive housing.

[ARC 4207C, IAB 1/2/19, effective 3/1/19]

441—25.6(331) Intensive mental health services. The purpose of intensive mental health services is to provide a continuum of services and supports to adults with complex mental health and multi-occurring conditions who need a high level of intensive and specialized support to attain stability in health, housing, and employment and to work toward recovery.

25.6(1) Access centers. The purpose of an access center is to serve adults experiencing a mental health or substance use crisis who are not in need of an inpatient psychiatric level of care and who do not have alternative, safe, effective services immediately available.

a. Regional coordination. Each region shall designate at least one access center provider and ensure that access center services are available to the residents of the region consistent with subrule 25.4(9).

(1) Regions shall work collaboratively to develop a minimum of six access centers strategically located throughout the state, with the support of the medical assistance program.

(2) Access centers may be shared by two or more regions.

(3) Each region shall establish methods to provide for reimbursement of a region when a non-Medicaid-eligible resident of another region utilizes an access center or other non-Medicaid-covered services located in that region.

b. Access center standards. A designated access center shall meet all of the following criteria:

(1) An access center shall have no residential facility-based setting with more than 16 beds.

(2) An access center provider shall be accredited to provide crisis stabilization residential services pursuant to 441—Chapter 24.

(3) An access center provider shall be licensed to provide subacute mental health services as described in rule 441—77.56(249A).

(4) An access center provider shall be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a cooperative agreement with and immediate access to licensed substance abuse treatment services or medical care that incorporates withdrawal management.

(5) An access center shall provide services on a no reject, no eject basis to individuals who meet service eligibility criteria.

(6) An access center shall accept and serve eligible individuals who are court-ordered to participate in mental health or substance use disorder treatment.

(7) An access center shall provide all required services listed in 25.6(1)“d” in a coordinated manner. An access center may provide coordinated services in one or more locations.

c. Eligibility for access center services. To be eligible to receive access center services, an individual shall meet all of the following criteria:

(1) The individual is an adult in need of screening, assessment, services or treatment related to a mental health or substance use crisis.

(2) The individual shows no obvious signs of illness or injury indicating a need for immediate medical attention.

(3) The individual has been determined not to need an inpatient psychiatric hospital level of care.

(4) The individual does not have immediate access to alternative, safe, and effective services.

d. Access center services. An access center shall provide or arrange for the provision of all of the following:

(1) Immediate intake assessment and screening that includes but is not limited to mental and physical health conditions, suicide risk, brain injury, and substance use. A crisis evaluation that includes all required screenings may serve as an intake assessment.

(2) Comprehensive person-centered mental health assessments by appropriately licensed or credentialed professionals, as indicated by the intake assessment.

(3) Comprehensive person-centered substance use disorder assessments by appropriately licensed or credentialed professionals, as indicated by the intake assessment.

(4) Peer support services, as indicated by a comprehensive assessment.

(5) Mental health treatment, as indicated by a comprehensive assessment.

(6) Substance use treatment, as indicated by a comprehensive assessment.

(7) Physical health care services as indicated by a health screening.

(8) Care coordination.

(9) Service navigation and linkage to needed services including housing, employment, shelter services, intellectual and developmental disability services, and brain injury services, with warm handoffs to other service providers.

25.6(2) Assertive community treatment (ACT) services. The purpose of assertive community treatment is to serve adults with the most severe and persistent mental illness conditions and functional impairments. ACT services provide a set of comprehensive, integrated, intensive outpatient services

delivered by a multidisciplinary team under the supervision of a psychiatrist, an advanced registered nurse practitioner, or a physician assistant under the supervision of a psychiatrist. An ACT program shall designate a staff member to be responsible for administration of the program and with the authority to sign documents and receive payments on behalf of the program.

a. Regional coordination. Each region shall designate at least one ACT provider and ensure that ACT services are available to the residents of the region consistent with subrule 25.4(9). Regions may work collaboratively with other regions when an ACT team is serving more than one region.

(1) Each region shall determine the number and size of ACT teams needed to serve the ACT-eligible population in that region.

(2) Each region shall verify that all ACT programs operating in the region have periodic fidelity reviews consistent with evidence-based practice standards published by the Substance Abuse and Mental Health Services Administration (SAMHSA). Each ACT program shall have a fidelity review, including a peer review, on the following schedule:

1. Within the first 12 months of operation.
2. Annually during each of the second and third years of operation.
3. Biennially thereafter for teams with satisfactory fidelity reviews. Teams with unsatisfactory reviews shall be reviewed again after one year.

Results of the ACT team fidelity reviews shall be included in the region's annual report.

b. ACT team composition. Each ACT team shall include a minimum of six members and must include a member qualified to fill each of the eight following roles. One team member may fill more than one role if all other qualifications are met.

(1) A psychiatrist, an advanced registered nurse practitioner, or a physician assistant under the supervision of a psychiatrist who is board-certified or eligible for board certification.

- (2) A team leader.
- (3) A registered nurse.
- (4) A mental health professional.
- (5) A substance abuse treatment provider.
- (6) A community support specialist.
- (7) A peer support specialist.
- (8) An employment specialist.

c. Staff qualifications. ACT team members shall meet the following qualifications:

(1) Psychiatrist. A psychiatrist on the team shall be a person who meets all of the following criteria:

1. Is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).
2. Is licensed in Iowa pursuant to 653—Chapter 9.
3. Is certified or is eligible to be certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry.

4. Has experience working with persons with severe and persistent mental illness.
5. Provides a minimum of 16 hours per week of psychiatrist time for every 50 ACT clients.

(2) Advanced registered nurse practitioner. An advanced registered nurse practitioner on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 655—Chapter 7.
2. Has a mental health certification.
3. Has experience working with persons with severe and persistent mental illness.
4. Provides a minimum of 16 hours per week of advanced registered nurse practitioner time for every 50 ACT clients.

(3) Physician assistant. A physician assistant on the team shall be a person who meets all of the following criteria:

1. Is licensed pursuant to 645—Chapter 326.
2. Has experience working with persons with severe and persistent mental illness.
3. Is practicing under the supervision of a psychiatrist who is board-certified or eligible for board certification.

4. Provides a minimum of 16 hours per week of physician assistant time for every 50 ACT clients.
 - (4) Team leader. A team leader shall be a person on the team who meets all of the following criteria:
 1. Has a master's degree in a mental health field, including but not limited to nursing, social work, mental health counseling, psychiatric rehabilitation, or psychology.
 2. Is actively involved in direct contact with individuals being served by the team.
 3. Is a full-time staff member whose responsibilities are limited to the ACT team and who serves as the clinical and administrative supervisor of the team.
 - (5) Registered nurse. A registered nurse on the team shall be a person who meets all of the following criteria:
 1. Is licensed as a registered nurse pursuant to 655—Chapter 3.
 2. Has experience working with persons with severe and persistent mental illness.
 - (6) Mental health professional. A mental health professional on the team shall be a person who meets all of the following criteria:
 1. Is a mental health counselor or marital and family therapist licensed pursuant to 645—Chapter 31; a social worker licensed as a master or independent social worker pursuant to 645—Chapter 280; or an occupational therapist licensed pursuant to 645—Chapter 206.
 2. Has experience working with persons with severe and persistent mental illness.
 - (7) Substance abuse treatment professional. A substance abuse treatment professional on the team shall be a person who meets all of the following criteria:
 1. Is an appropriately credentialed counselor pursuant to 641—subparagraph 155.21(8) "b"(1).
 2. Has at least three years of experience working with persons with substance use disorders.
 - (8) Community support specialist. A community support specialist on the team shall be a person who meets all of the following criteria:
 1. Has a bachelor's degree with at least 30 semester hours or equivalent quarter hours in a human services field, including but not limited to sociology, social work, counseling, psychology, or human services.
 2. Has experience working with persons with severe and persistent mental illness.
 - (9) Peer support specialist. A peer support specialist on the team shall be a person who meets all of the following criteria:
 1. Has been diagnosed with a severe and persistent mental illness.
 2. Has met all requirements of the Appalachian Consulting Group Peer Support Training Model by no later than six months after the date of hire.
 - (10) Employment specialist. An employment specialist on the team shall be a person who meets all of the following criteria:
 1. Has experience working with persons with severe and persistent mental illness.
 2. Meets one of the following:
 - Has a bachelor's degree with at least 30 semester hours or equivalent quarter hours in a human services field, including but not limited to sociology, social work, counseling, or psychology, and completes at least 12 hours of employment services training within six months of the date of hire.
 - Has a high school diploma or equivalent, has at least one year of specialized vocational training or supervised experience in vocational and related services, including but not limited to supported employment, job coaching, supported community living, or habilitation, and completes at least 12 hours of employment services training within six months of the date of hire.
 - (11) Psychologist. A psychologist on the team shall be a person who meets all of the following criteria:
 1. Is licensed pursuant to 645—Chapter 240.
 2. Has experience working with persons with a severe and persistent mental illness.
- d. ACT provider standards.* Organizations seeking regional designation as an ACT provider shall meet the following criteria at initial application and annually thereafter. A designated ACT provider shall:
- (1) Develop and maintain written ACT-specific admission policies and procedures, including but not limited to a gradual rate of admission and program eligibility requirements.

(2) Develop and maintain written ACT-specific discharge policies and procedures. Discharge criteria shall include but are not limited to the following:

1. An individual reaches individually established goals for discharge, and the individual and program staff mutually agree to the termination of services; or

2. An individual requests discharge, demonstrates the ability to function in all major role areas without ongoing assistance from the program and without significant relapse when services are withdrawn, and the program staff agree to the termination of services; or

3. An individual moves outside the geographic area of the team's responsibility. In such cases, the team shall arrange for transfer of responsibility for mental health services to an ACT program or another provider wherever the individual is relocating, and the team shall maintain contact with the individual until the service transfer is implemented; or

4. An individual declines or refuses services and requests discharge despite the team's best efforts to develop an acceptable treatment plan with the individual.

(3) Documentation of discharges. Documentation shall include:

1. The reason(s) for discharge as stated by both the individual and the team.

2. A summary of the individual's biopsychosocial status at the time of discharge.

3. A written final evaluation summary of the individual's progress toward the goals in the treatment plan.

4. A plan developed in conjunction with the individual for follow-up treatment after discharge.

5. The signature of each of the following:

- The individual, or documentation of why the individual's signature was not obtained.

- The service coordinator.

- The team leader.

- The psychiatrist, advanced registered nurse practitioner, or physician assistant under the supervision of a board-certified psychiatrist.

e. ACT team standards. All designated ACT teams shall:

(1) Participate in all of the individual's mental health services.

(2) Ensure that services for the psychiatric needs of the individual are available 24 hours a day.

(3) Develop a specific treatment plan based on the assessment of needs and including goals and actions to address the individual's medical, social, educational, and other needs.

(4) Make referrals to services and related activities to assist the individual with the individual's assessed needs.

(5) Monitor and perform follow-up activities necessary to ensure that the treatment plan is carried out and that the individual has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

(6) Hold team meetings at least four times a week to facilitate ACT services and briefly review the status of the individual with other members of the team.

(7) Have the capacity to provide multiple contacts a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in a living situation or employment, or having significant ongoing problems in daily living. All members of the team share responsibility for addressing the needs of all individuals. The number of team contacts per individual served shall average at least three per week per individual when calculated across all individuals served by the team. Contacts may be weekly, daily, or more frequent. The frequency of contacts is determined by the needs of the individual.

(8) Have the capacity to rapidly increase service intensity to an individual when the individual's status requires it or the individual requests it.

(9) Ensure that treatment, rehabilitation, and support activities are available 24 hours a day, 7 days a week, 365 days a year, including nights, weekends, and holidays. If there are insufficient numbers of staff to operate an after-hours on-call system, staff shall provide crisis response during regular work hours and arrange coverage for all other hours through a reliable crisis response service.

(10) Provide no more than 20 percent of service contacts in office-based settings.

f. Staff-to-client ratio. ACT teams shall maintain a ratio of at least one full-time or full-time equivalent staff person to every ten individuals served. The ACT team staff-to-client ratios do not include the psychiatrist, advanced nurse practitioner, or physician assistant practicing under the supervision of a psychiatrist.

g. Eligibility criteria for ACT services. To be eligible to receive ACT services, the individual shall meet all of the following criteria:

(1) Is at least 17 years of age.

(2) Has a severe and persistent mental illness or complex mental health symptomology. Individuals with a primary diagnosis of substance use disorder, developmental disability, personality disorder, or organic disorder are not eligible for ACT services.

(3) Is in need of a consistent team of professionals and multiple mental health and support services to live independently in the community and reduce hospitalizations, as evidenced by one or both of the following:

1. A pattern of repeated treatment failures during the previous 12 months, including at least two psychiatric hospitalizations or psychiatric care delivered at least twice in an emergency department, at an access center, or by a mobile crisis team; or

2. The need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

(4) Presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the individual's functioning and assist the individual in achieving or maintaining independent community living. Specifically, the individual:

1. Is medically stable;

2. Does not require a level of care that includes more intensive medical monitoring;

3. Presents a low risk to self, others, or property, with treatment and support; and

4. Lives independently in the community or demonstrates a capacity and desire to live independently in the community.

h. ACT services. ACT teams shall provide the following services:

(1) Initial assessment and treatment planning.

1. An assessment of the individual shall be completed within 30 days of admission that includes psychiatric history, medical history, educational history, employment, substance use, problems with activities of daily living, social interests, and family relationships.

2. An individualized written treatment plan shall be developed based on the assessment. The treatment plan shall identify the necessary psychiatric rehabilitation treatment and support services, including all of the following:

- Treatment objectives and outcomes.
- The expected frequency and duration of each service.
- The location where the services will be provided.
- A crisis plan.
- The schedule for updates of the treatment plan.

(2) Evaluation and medication management.

1. The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the individual by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

2. Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant in response to the individual's complaints and symptoms. A psychiatric registered nurse assists in this management by making contact with the individual regarding medications and their effect on the individual's complaints and symptoms.

(3) Integrated therapy and counseling for mental health and substance abuse. Integrated therapy and counseling consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling may be provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

(4) Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by any team member.

(5) Community support. Community support may be provided by any team member and consists of the following activities focused on recovery and rehabilitation:

1. Personal and home skills training to assist the individual to develop and maintain skills for self-direction and coping with the living situation.

2. Community skills training to assist the individual in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

(6) Medication monitoring. Medication monitoring services shall be provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consists of:

1. Monitoring the individual's day-to-day functioning, medication compliance, and access to medications; and

2. Ensuring that the individual keeps appointments.

(7) Case management for treatment and service plan coordination. Case management consists of the development of an individualized treatment and service plan, including personalized goals and outcomes, to address the individual's medical symptoms and remedial functional impairments. Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the individual in gaining access to necessary medical, social, educational, and other services.

3. Assessing the individual to determine service needs by collecting relevant historical information through records and other information from relevant professionals and natural supports.

(8) Crisis response. Crisis response consists of direct assessment and treatment of the individual's urgent or crisis symptoms in the community by any team member, as appropriate.

(9) Work-related services. Work-related services may be provided by any team member. Services consist of assisting the individual in managing mental health symptoms as they relate to job performance and may include:

1. Collaborating with the individual to look for job situations of the individual's choice and creating strategies to manage situations that cause symptoms to increase.

2. Assisting the individual to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

3. Providing supports to maintain employment, such as crisis intervention related to employment.

4. Teaching communication, problem-solving, and safety skills.

5. Teaching personal skills, such as time management and appropriate grooming for employment.

(10) Peer support services. Peer support services are provided by a peer support specialist and include, but are not limited to, education and information, individual advocacy, and crisis response.

(11) Support services. All team members are responsible for providing support services. Services consist of assisting the individual in obtaining the basic necessities of daily life, including but not limited to:

1. Medical and dental services.

2. Safe, clean, and affordable housing.

3. Financial support.

4. Benefits counseling.

5. Social services.

6. Transportation.

7. Legal advocacy and representation.

(12) Education, support, and consultation to family members and other major supports of individuals. All team members are responsible for providing education, support, and consultation to family members and other major supports of individuals with the agreement or consent of the individual. Services include but are not limited to:

1. Individualized psychoeducation about the individual's illness and the role of the family and other significant people in the therapeutic process.
2. Intervention to restore contact, resolve conflicts, and maintain relationships with family or other significant people or both.
3. Ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family.
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.
5. Assistance to obtain necessary services for individuals with children, including but not limited to:
 - Individual supportive counseling.
 - Parenting training.
 - Service coordination.
 - Services to help the individual throughout pregnancy and the birth of a child.
 - Services to help the individual fulfill parenting responsibilities and coordinate services for the child or children.
 - Services to help the individual restore relationships with children who are not in the individual's custody.

25.6(3) *Mobile response.* The purpose of mobile response is to provide short-term individualized crisis stabilization, following a crisis screening or assessment, that is designed to restore the individual to a prior functional level. Mobile response services shall be provided as described in rule 441—24.36(225C).

25.6(4) *23-hour observation and holding.* The purpose of 23-hour observation and holding is to provide up to 23 hours of care for adults in a safe and secure, medically staffed treatment environment. Twenty-three-hour observation and holding shall be provided as described in rule 441—24.37(225C).

25.6(5) *Crisis stabilization community-based services.* The purpose of crisis stabilization community-based services is to provide short-term services designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis in the setting where the individual lives, works, or recreates. Crisis stabilization community-based services shall be provided as described in rule 441—24.38(225C).

25.6(6) *Crisis stabilization residential services.* The purpose of crisis stabilization residential services is to provide a short-term alternative living arrangement in a setting of no more than 16 beds that is designed to de-escalate a crisis situation and stabilize an individual following a mental health crisis. Crisis stabilization residential services shall be provided as described in rule 441—24.39(225C).

25.6(7) *Subacute mental health services.* The purpose of subacute mental health services is to provide a comprehensive set of wraparound services to adults who have had or are at imminent risk of having acute or crisis mental health symptoms.

a. Regional coordination. Each region shall designate at least one subacute mental health service provider and ensure that subacute mental health services are available to the residents of the region consistent with subrule 25.4(4).

b. Subacute mental health services standards.

(1) Subacute mental health services in a facility-based setting shall be provided as described in Iowa Code chapter 135G and 481—Chapter 71.

(2) Subacute mental health services in a community-based setting are the same as assertive community treatment (ACT) services provided as described in subrule 25.6(2).

25.6(8) *Intensive residential services.* The purpose of intensive residential services is to serve adults with the most intensive severe and persistent mental illness conditions who have functional impairments and may also have multi-occurring conditions. Intensive residential services provide intensive 24-hour supervision, behavioral health services, and other supportive services in a community-based residential setting.

a. Regional coordination. Each region shall designate at least one intensive residential services provider and ensure that intensive residential services are available to the residents of the region consistent with subrule 25.4(9).

(1) Regions shall work collaboratively to develop intensive residential services strategically located throughout the state with the capacity to serve a minimum of 120 individuals, with the support of the medical assistance program.

(2) Intensive residential services may be shared by two or more regions.

(3) Each region shall establish methods to provide for reimbursement of a region when the non-Medicaid-eligible resident of another region utilizes intensive residential services or other non-Medicaid-covered services located in that region.

b. Intensive residential services standards. An organization that seeks regional designation as an intensive residential service provider shall meet the following criteria at initial application and annually thereafter. A designated intensive residential service provider shall:

(1) Be enrolled as an HCBS 1915(i) habilitation provider or an HCBS 1915(c) intellectual disability waiver supported community living provider in good standing with the Iowa Medicaid enterprise.

(2) Provide staffing 24 hours a day, 7 days a week, 365 days a year.

(3) Maintain a minimum staffing ratio of one staff to every two and one-half residents. Staffing ratios shall be responsive to the needs of the individuals served.

(4) Ensure that all staff members have the following minimum qualifications:

1. One year of experience working with individuals with a mental illness or multi-occurring conditions.

2. A high school diploma or equivalent.

(5) Ensure that within the first year of employment, staff members complete 48 hours of training in mental health and multi-occurring conditions. During each consecutive year of employment, staff members shall complete 24 hours of training in mental health and multi-occurring conditions. Staff training shall include, but is not limited to the following:

1. Applied behavioral analysis.

2. Autism spectrum disorders, diagnoses, symptomology and treatment.

3. Brain injury diagnoses, symptomology and treatment.

4. Crisis management and de-escalation and mental health diagnoses, symptomology and treatment.

5. Motivational interviewing.

6. Psychiatric medications.

7. Substance use disorders and treatment.

8. Other diagnoses or conditions present in the population served.

(6) Provide coordination with the individual's clinical mental health and physical health treatment, and other services and supports.

(7) Provide clinical oversight by a mental health professional. The mental health professional shall review and consult on all behavioral health services provided to the individual, and any other plans developed for the individual, including but not limited to service plans, behavior intervention plans, crisis intervention plans, emergency plans, cognitive rehabilitation plans, or physical rehabilitation plans.

(8) Have a written cooperative agreement with an outpatient mental health provider and ensure that individuals have timely access to outpatient mental health services, including but not limited to ACT.

(9) Be licensed as a substance abuse treatment program pursuant to Iowa Code chapter 125 or have a written cooperative agreement with and timely access to licensed substance abuse treatment services for those individuals with a demonstrated need.

(10) Accept and serve eligible individuals who are court-ordered to intensive residential services.

(11) Provide services to eligible individuals on a no reject, no eject basis.

(12) If funded through HCBS and not licensed as a residential care facility, serve no more than five individuals at a site.

(13) Be located in a neighborhood setting to maximize community integration and natural supports.

(14) Demonstrate specialization in serving individuals with an SPMI or multi-occurring conditions and serve individuals with similar conditions in the same site.

c. Eligibility criteria for admission to intensive residential services. To be eligible to receive intensive residential services, an individual shall meet all of the following criteria:

(1) The individual is an adult with a diagnosis of a severe and persistent mental illness or multi-occurring conditions.

(2) The individual is approved by the Iowa Medicaid enterprise or Medicaid managed care organization, as appropriate, for the highest rate of home-based habilitation or the highest rate of home- and community-based services intellectual disability waiver supported community living service. Reimbursement rates for intensive residential services shall be equal to or greater than the established fees for those services. Regional reimbursement rates for non-Medicaid individuals receiving intensive residential services shall be negotiated by the region and the provider and shall be no less than the minimum Medicaid rate.

(3) The individual has had a standardized functional assessment and screening for multi-occurring conditions completed 30 days or less prior to application for intensive residential services, and the functional assessment and screening demonstrates that the individual:

1. Has a diagnosis that meets the criteria of severe and persistent mental illness as defined in rule 441—25.1(331);

2. Has three or more areas of significant impairment in activities of daily living or instrumental activities of daily living;

3. Is in need of 24-hour supervised and monitored treatment to maintain or improve functioning and avoid relapse that would require a higher level of treatment;

4. Has exhibited a lack of progress or regression after an adequate trial of active treatment at a less intensive level of care;

5. Is at risk of significant functional deterioration if intensive residential services are not received or continued; and

6. Meets one or more of the following:

- Has a record of three or more psychiatric hospitalizations in the 12 months preceding application for intensive residential services.

- Has a record of more than 30 medically unnecessary psychiatric hospital days in the 12 months preceding application for intensive residential services.

- Has a record of more than 90 psychiatric hospital days in the 12 months preceding application for intensive residential services.

- Has a record of three or more emergency room visits related to a psychiatric diagnosis in the 12 months preceding application for intensive residential services.

- Is residing in a state resource center and has an SPMI.

- Is being served out of state due to the unavailability of medically necessary services in Iowa.

- Has an SPMI and is scheduled for release from a correctional facility or a county jail.

- Is homeless or precariously housed.

[ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.7(331) Non-core services. When a mental health and disability services region chooses to make the following non-core services available, the region shall ensure that such services meet the requirements of this rule.

25.7(1) Prescreening assessments. Prescreening assessments provided by the region or an entity contracting with the region shall meet the following requirements:

a. The prescreening assessment shall be provided in an emergency room or other crisis assessment setting within four hours of an emergency detention of an individual believed to be mentally ill to determine if inpatient psychiatric hospitalization is necessary.

b. The prescreening assessment shall be performed by a licensed physician or mental health professional who shall also provide ongoing consultations while the individual remains in the emergency room or other crisis assessment setting. The services provided by the consulting professional are

intended to supplement, but do not replace, the services of the emergency room or other crisis setting staff.

c. The licensed physician or mental health professional shall submit appropriate documentation and reports to the emergency room or other crisis setting and the court as necessary.

d. The region or entity contracting with the region shall ensure the coordination of appropriate levels of care. Coordination may include but is not limited to:

(1) Securing an inpatient psychiatric bed when inpatient psychiatric hospitalization is needed.

(2) Utilizing community-based resources and services such as 23-hour observation and holding, crisis stabilization community-based or residential services, subacute facility-based mental health services or detoxification centers.

(3) Facilitating outpatient treatment appointments when inpatient psychiatric hospitalization is not needed.

25.7(2) Transportation. A service provider that is under contract with a region and transports individuals pursuant to an Iowa Code chapter 229 court order shall meet the following requirements:

a. The transport vehicle shall be secure such that the individual being transported cannot open doors or windows of the vehicle while it is moving.

b. Transportation staff shall complete a minimum of eight hours of training in mental health issues and crisis intervention in the first month of employment. After the initial training, each staff member shall complete a minimum of two hours of training annually.

[ARC 4207C, IAB 1/2/19, effective 3/1/19]

These rules are intended to implement Iowa Code chapter 331.

441—25.8 to 25.10 Reserved.

DIVISION II
REGIONAL SERVICE SYSTEM

PREAMBLE

These rules define the standards for a regional service system. The mental health and disability services and children's behavioral health services provided by counties operating as a region shall be delivered in accordance with a regional service system management plan approved by the region's governing board and implemented by the regional administrator (Iowa Code section 331.393). Iowa counties are encouraged to enter into a regional system when the regional approach is likely to increase the availability of services to residents of the state who need the services. It is the intent of the Iowa general assembly that the adult residents of this state should have access to needed mental health and disability services and that Iowa children should have access to needed behavioral health services regardless of the location of their residence.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.11(331) Definitions.

"Access point" means a provider, public or private institution, advocacy organization, legal representative, or educational institution with staff trained to complete applications and guide individuals with a disability to needed services.

"Assessment and evaluation" means the same as defined in rule 441—25.1(331).

"Assistive technology account" means funds in contracts, savings, trust or other financial accounts, financial instruments, or other arrangements with a definite cash value that are set aside and designated for the purchase, lease, or acquisition of assistive technology, assistive technology services, or assistive technology devices. Assistive technology accounts must be held separately from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology services or devices for a working individual with a disability. Any withdrawal from an assistive technology account other than for the designated purpose becomes a countable resource.

"Authorized representative" means a person designated by the individual or by Iowa law to act on the individual's behalf in specified affairs to the extent prescribed by law.

“*Cash flow*” means the same as “ending fund balance.”

“*Chief executive officer*” means the person chosen and supervised by the governing board who serves as the single point of accountability for the mental health and disability services region and whose responsibilities include, but are not limited to, planning, budgeting, monitoring county and regional expenditures, and ensuring the delivery of quality services that achieve expected outcomes for the individuals served.

“*Choice*” means the individual or authorized representative chooses the services, supports, and goods needed to best meet the individual’s goals and accepts the responsibility and consequences of those choices.

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

“*Community*” means an integrated setting of an individual’s choice.

“*Conflict-free case management*” means there is no real or seeming incompatibility between the case manager’s other interests and the case manager’s duties to the individual served and includes case management separate from direct service provision; eligibility determination for services; establishment of funding levels for the individual’s services; and requirements that prohibit the case manager from performing evaluations, assessments, and plans of care if the case manager is related by blood or marriage to the individual or any of the individual’s paid caregivers or persons financially responsible for the individual or empowered to make financial or health-related decisions on behalf of the individual.

“*Coordinator of children’s behavioral health services*” means a member of the regional administrative entity staff who meets the requirements described in Iowa Code section 331.390(3) “b” and is responsible for coordinating behavioral health services for children.

“*Coordinator of mental health and disability services*” means a member of the regional administrative entity staff who meets the requirements described in Iowa Code section 331.390(3) “b” and is responsible for coordinating mental health and disability services for adults.

“*Countable household income*” means earned and unearned income of the family of a child according to the modified adjusted gross income methodology.

“*Countable resource*” means real or personal property that has a cash value that is available to the owner upon disposition and is capable of being liquidated.

“*Countable value*” means the equity value of a resource, which is the current fair market value minus any legal debt on the item.

“*County of residence*” means the same as defined in Iowa Code section 331.394.

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

“*Director*” means the director of human services.

“*Disability services*” means the same as defined in Iowa Code section 225C.2.

“*Emergency service*” means the same as defined in rule 441—88.21(249A).

“*Empowerment*” means that the service system ensures the rights, dignity, and ability of individuals and their families to exercise choices, take risks, provide input, and accept responsibility.

“*Encumbered*” or “*encumbrances*” means regional commitments related to obligations or contracts as defined in subrule 25.13(6).

“*Ending balance limitation*” means the percentage limit allowable by state law that a region’s ending fund balance can exceed actual expenditures for the previous fiscal year.

“*Ending balance threshold*” means the same as defined in Iowa Code section 225C.7A.

“*Ending fund balance*” means the amount of residual funds remaining in a region’s combined account at the conclusion of a fiscal year after the region has met the financial obligations for implementation of its regional service system management plan.

“*Exempt resource*” means a resource that is disregarded in the determination of eligibility for public funding assistance and in the calculation of client participation amounts.

“*Federal poverty level*” means the most recently revised annual poverty income guidelines published in the Federal Register by the United States Department of Health and Human Services.

“Homeless person” means the same as defined in Iowa Code section 48A.2.

“Household” means, for an individual who is 18 years of age or over, the individual, the individual’s spouse or domestic partner, and any children, stepchildren, or wards under the age of 18 who reside with the individual. For an individual under the age of 18, “household” means the individual, the individual’s parents (or parent and domestic partner), stepparents or guardians, and any children, stepchildren, or wards under the age of 18 of the individual’s parents (or parent and domestic partner), stepparents, or guardians who reside with the individual.

“Income” means all gross income received by the individual’s household, including but not limited to wages, income from self-employment, retirement benefits, disability benefits, dividends, annuities, public assistance, unemployment compensation, alimony, child support, investment income, rental income, and income from trust funds.

“Individual” means any person seeking or receiving services in a regional service system.

“Individualized services” means services and supports that are tailored to meet the personalized needs of the individual.

“Liquid assets” means assets that can be converted to cash in 20 days. Liquid assets include but are not limited to cash on hand, checking accounts, savings accounts, stocks, bonds, cash value of life insurance, individual retirement accounts, certificates of deposit, and other investments.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors: achieving high-quality outcomes for participants, coordinating access, and containing costs.

“Managed system” means a system that integrates planning, administration, financing, and service delivery. The system consists of the financing or governing organization, the entity responsible for care management, and the network of service providers.

“Management organization” means an organization contracted to manage part or all of the service system for a region.

“Medical savings account” means an account that is exempt from federal income taxation pursuant to Section 220 of the U.S. Internal Revenue Code (26 U.S.C. §220) as supported by documentation provided by the bank or other financial institution. Any withdrawal from a medical savings account other than for the designated purpose becomes a countable resource.

“Mental health professional” means the same as defined in Iowa Code section 228.1(6).

“Modified adjusted gross income” means the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603.

“Non-liquid assets” means assets that cannot be converted to cash in 20 days. Non-liquid assets include, but are not limited to, real estate, motor vehicles, motor vessels, livestock, tools, machinery, and personal property.

“Population” means the same as defined in Iowa Code section 331.388.

“Provider” means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance, is accredited under 441—Chapter 24, holds a professional license to provide the service, is accredited by a national insurance panel, or holds other national accreditation or certification.

“Region incentive fund” means the same as defined in Iowa Code section 225C.7A.

“Regional administrator” or *“regional administrative entity”* means the administrative office or organization formed by agreement of the counties participating in a mental health and disability services region to function on behalf of those counties.

“Regional service growth factor” means the same as defined in Iowa Code section 225C.7A.

“Regional services fund” means the mental health and disability regional services fund created in Iowa Code section 225C.7A.

“Regional service system management plan” means the regional service system plan developed pursuant to Iowa Code section 331.393 for the funding and administration of non-Medicaid-funded mental health and disability services and includes an annual service and budget plan, a policies and

procedures manual, and an annual report and how the region will coordinate with the department in the provision of mental health and disability services funded under the medical assistance program.

“*Resources*” means all liquid and non-liquid assets that are owned in part or in whole by the individual household, that could be converted to cash to use for support and maintenance, and that the individual household is not legally restricted from using for support and maintenance.

“*Retirement account*” means any retirement or pension fund or account listed in Iowa Code section 627.6(8)“f.”

“*Retirement account in the accumulation stage*” means a retirement account into which a deposit was made in the previous tax year. Any withdrawal from a retirement account becomes a countable resource.

“*Service system*” refers to the mental health and disability services and supports administered by the regional administrative entity and paid from the regional services fund.

“*State case status*” means the standing of an individual who has no county of residence.

“*State commission*” means the same as defined in Iowa Code section 225C.5.

“*System of care*” means the coordination of a system of services and supports to individuals and their families that ensures they optimally live, work, and recreate in integrated communities of their choice.

“*System principles*” means practices that include individual choice, community and empowerment. [ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20; ARC 6008C, IAB 11/3/21, effective 10/4/21; ARC 6195C, IAB 2/9/22, effective 3/16/22; ARC 6237C, IAB 3/9/22, effective 5/1/22]

441—25.12(331) Regional governance structure. The counties comprising a mental health and disability services region shall enter into an agreement to form a regional administrator under the control of a governing board to function on behalf of those counties as defined in Iowa Code chapter 28E and sections 331.388, 331.390, 331.392 and 331.399.

25.12(1) Governing board. The governing board shall comply with the provisions of Iowa Code section 331.390, Iowa Code chapter 69 and other applicable laws relating to boards and commissions, including but not limited to the following:

a. The governing board shall include the following voting members:

(1) At least one board of supervisors member from each county comprising the region or their designees.

(2) One adult person who utilizes mental health and disability services or is an actively involved relative of an adult who utilizes such services, designated by the regional adult mental health and disability services advisory committee.

(3) Members designated by the regional children’s behavioral health services advisory committee as follows:

1. One member representing the education system in the region.

2. One member who is a parent of a child who utilizes children’s behavioral health services or is an actively involved relative of a child who utilizes such services.

b. The governing board shall include the following nonvoting members in an ex officio capacity:

(1) One member representing an adult service provider in the region, designated by the regional adult mental health and disability services advisory committee.

(2) One member representing a children’s behavioral health service provider in the region, designated by the regional children’s behavioral health services advisory committee.

c. The governing board shall create a regional adult mental health and disability services advisory committee, which shall designate members to the governing board as defined in Iowa Code section 331.390(2).

d. The governing board shall create a regional children’s behavioral health services advisory committee, which shall designate members to the governing board as defined in Iowa Code section 331.390(2).

e. The governing board shall appoint and evaluate the performance of the chief executive officer of the regional administrative entity who will serve as the single point of accountability for the region.

25.12(2) Regional administrator. The formation of the regional administrator shall be as defined in Iowa Code sections 331.388 and 331.390.

- a. The regional administrative entity is under the control of the governing board.
- b. The regional administrative entity shall enter into and manage performance-based contracts in accordance with Iowa Code section 225C.4(1)“u.”
- c. The regional administrative entity structure shall have clear lines of accountability.
- d. The regional administrative entity functions as a lead agency utilizing shared county or regional staff or other means of limiting administrative costs.
- e. The regional administrative entity staff shall include one or more coordinators of mental health and disability services.
- f. The regional administrative entity staff shall include one or more coordinators of children’s behavioral health services.

25.12(3) Regional service system management. The region may either directly implement a system of service management and contract with service providers, or contract with a private entity to manage the regional service system, provided all requirements of Iowa Code section 331.393 are met by the private entity.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.13(331) Regional finances.

25.13(1) Regional service payments. The department will distribute funds from the mental health and disability services regional service fund to regions in accordance with Iowa Code section 225C.7A. Funds will be distributed in July, October, January, and April.

25.13(2) Funding. Funding for non-Medicaid mental health and disability services and children’s behavioral health services is under the control of the governing board and shall:

- a. Be maintained to limit administrative burden and provide public transparency regarding financial processes.
- b. Be maintained in a combined account.
- c. Be used to fund services in accordance with the regional service system management plan and the performance-based contract.
- d. Be maintained in a county mental health and disability services fund for the deposit of regional service payments for those counties exempted under Iowa Code section 331.389. Expenditures to be made from the county mental health and disability services fund will not be made from any other fund of the county. The exempted county mental health and disability services fund is considered to be the same as a region combined account and is subject to the same requirements as a region combined account.

25.13(3) Accounting system and financial reporting. The accounting system and financial reporting to the department shall conform to Iowa Code section 331.391 and include all non-Medicaid mental health and disability expenditures. Information shall be separated and identified in a uniform chart of accounts, including but not limited to the following: expenses for administration; purchase of services; and enterprise costs for which the region is a service provider or is directly billing and collecting payments.

25.13(4) Ending fund balance. Each region shall certify to the department of human services on or before December 1 the region’s cash flow amount in the combined account at the conclusion of the most recently completed fiscal year.

- a. A region must submit the ending fund balance on forms specified by the department.
- b. The certified ending fund balance shall exclude encumbered amounts for which resources already have been committed and been approved by the department in accordance with subrule 25.13(7).
- c. A certified submission must:
 - (1) Be approved by the region’s governing board prior to submittal to the department.
 - (2) Be signed by the chairperson of the regional governing board and the regional chief executive officer.

25.13(5) Ending balance limitations.

a. A region's certified ending fund balance as determined in subrule 25.13(4) will not exceed a percentage of the region's actual expenditures for the preceding fiscal year. The ending balance limitations are as follows:

(1) For the fiscal year beginning July 1, 2021, the ending balance shall be no more than 40 percent of the actual expenditures of that year.

(2) For the fiscal year beginning July 1, 2022, the ending balance shall be no more than 20 percent of the actual expenditures of that year.

(3) For the fiscal year beginning July 1, 2023, and each succeeding fiscal year thereafter, the ending balance shall be no more than 5 percent of the actual expenditures of that year.

b. If a region has an ending fund balance more than the limitation, the department will reduce the current fiscal year's remaining quarterly regional service payments equal to the excess ending fund balance amount.

c. If withholding a region's remaining quarterly payments does not sufficiently effectuate the required reduction, the region shall pay to the department any additional excess ending fund balance amount.

d. The amount of reductions to regional service payments and amounts paid to the department under paragraph 25.13(5) "c" shall be transferred and credited to the regional incentive fund.

25.13(6) *Acceptable encumbrances.* A region shall report to the department moneys for which a commitment is imposed and binding.

a. Financial obligations entered into by the region may be considered an acceptable encumbrance under the following circumstances:

(1) Existence of evidence as demonstrated by a contract or purchase order that details the services to be delivered and cost to the region.

(2) Entry of the region into executed contracts or binding commitments shall occur through formal action of the region's governing board.

b. Acceptable encumbrances shall be entered into and fulfilled according to the time frames outlined below:

(1) For the fiscal year beginning July 1, 2021, funds shall be obligated by the end of the fiscal year. Services shall be fully executed and moneys expended by June 30, 2023.

(2) For the fiscal year beginning July 1, 2022, funds shall be obligated by the end of the fiscal year. Services shall be fully executed and moneys expended by December 31, 2023.

(3) For the fiscal year beginning July 1, 2023, and each succeeding fiscal year thereafter, funds shall be obligated by the end of the current fiscal year. Services shall be fully executed and moneys expended by August 31 of the subsequent fiscal year.

c. Up to 10 percent of the direct and purchased administration expenditure total identified in the region's current approved annual service and budget plan may be claimed as an encumbrance.

d. Requests to encumber funds toward multiyear projects with the purpose to provide access to required core services shall be limited to actual needs for the current fiscal year.

25.13(7) *Encumbrance reporting and approval.*

a. The region shall submit a detailed accounting of encumbered funds to the department on or before July 31 on forms specified by the department.

(1) The department may request additional information to determine whether the region's reported contracts and binding commitments qualify as acceptable encumbrances.

(2) A plan for expenditure, including a description of activities related to required core services, shall accompany documentation for multiyear projects.

b. By August 31, the department shall notify the region, in writing, of the decision and the accepted amount to be considered encumbered. The decision of the department is final.

c. Regional commitments that are denied as acceptable encumbrances shall be included in the calculation of the ending fund balance for the previous fiscal year.

d. Encumbrances that are not fulfilled within the time frames specified in subrule 25.13(6) shall be included in the ending fund balance amount.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20; ARC 6237C, IAB 3/9/22, effective 5/1/22]

441—25.14(331) Regional governance agreement. The expectations for regional governance agreements entered into by the counties comprising a mental health and disability services region are defined in Iowa Code sections 28E.1, 331.388, 331.390 and 331.392.

25.14(1) Organizational provisions. The organizational provisions of the regional governance agreement shall include the following:

- a. A statement of purpose, goals, and objective of entering into the agreement.
- b. Identification of the governing board membership and the terms, methods of appointment, and voting procedures, including whether or not voting will be weighted.
- c. The identification of the process for selecting the executive staff, including but not limited to the chief executive officer of the regional administrative entity.
- d. Identification of the counties participating in the agreement.
- e. The time period of the agreement and terms for termination or renewal of the agreement.
- f. Provisions for joining a region. Additional counties may join the region. The agreement shall not prohibit a county from being assigned by the department to a region according to Iowa Code section 331.389(4) “c.”
- g. Methods for dispute resolution and mediation.
- h. Methods for termination of a county’s participation in the region.
- i. Provision for formation and assigned responsibilities for one or more regional advisory committees for adult mental health and disability services consisting of:
 - (1) Individuals who utilize services or the actively involved relatives of such individuals.
 - (2) Service providers of adult mental health and disability services.
 - (3) Governing board members.
 - (4) Other interests identified in the agreement.
- j. Provision for formation and assigned responsibilities for one or more regional advisory committees for children’s behavioral health services consisting of:
 - (1) A parent of a child who utilizes services or an actively involved relative of such child.
 - (2) A member of the education system.
 - (3) An early childhood advocate.
 - (4) A child welfare advocate.
 - (5) A children’s behavioral health service provider.
 - (6) A member of the juvenile court.
 - (7) A pediatrician.
 - (8) A child care provider.
 - (9) A local law enforcement representative.
 - (10) A regional governing board member.

25.14(2) Administrative provisions. The administrative provisions of the regional governance agreement shall include all of the following:

- a. Identification of whether the region will either directly implement a system of service management or contract with a private entity to manage the regional service system as defined in Iowa Code section 331.393(7).
- b. Responsibility of the governing board in appointing and evaluating the performance of the chief executive officer of the regional administrative entity.
- c. A general list of the functions and responsibilities of the regional administrative entity’s chief executive officer and other staff including but not limited to coordinators of mental health and disability services and coordinators of children’s behavioral health services.
- d. Specification of the functions to be carried out by each party to the agreement and by any subcontractor of a party to the agreement.

25.14(3) Financial provisions. The financial provisions of the regional governance agreement shall include all of the following:

- a. Methods for pooling, managing and expending funds under control of the regional administrative entity.
- b. Methods for allocating administrative funding and resources.

c. Methods for allocating a region's cash flow amount in the event a county leaves the region. A region's cash flow amount shall be divided by the percentage of each county's population according to the region's population indicated in the region's annual service and budget plan and shall be allocated to the counties.

d. Methods for contributing initial funds to the region.

e. Methods for acquiring or disposing of real property.

f. The process for how to use savings achieved for reinvestment.

g. A process for performance of an annual independent audit of the regional administrator.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20; ARC 5956C, IAB 10/6/21, effective 12/1/21; ARC 6237C, IAB 3/9/22, effective 5/1/22]

441—25.15(331) Eligibility, diagnosis, and functional assessment criteria.

25.15(1) Eligibility for mental health services. An individual must comply with all of the following requirements to be eligible for mental health services under the regional service system:

a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has had at any time during the preceding 12-month period a mental health, behavioral, or emotional disorder or, in the opinion of a mental health professional, may now have such a diagnosable disorder. The diagnosis shall be made in accordance with the criteria provided in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and shall not include the manual's "V" codes identifying conditions other than a disease or injury. The diagnosis shall also not include substance-related disorders, dementia, antisocial personality, or developmental disabilities, unless co-occurring with another diagnosable mental illness.

e. The results of a standardized functional assessment support the need for mental health services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for mental health services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(2) Eligibility for children's behavioral health services. An individual must comply with all of the following requirements to be eligible for children's behavioral health services under the regional service system:

a. The individual is a child under 18 years of age.

b. The child's custodial parent is a resident of the state of Iowa, and the child is physically present in the state.

c. The child's family meets the financial eligibility requirements in rule 441—25.16(331).

d. The child has been diagnosed with a serious emotional disturbance. A serious emotional disturbance diagnosis is not required to access comprehensive facility and community-based crisis services according to Iowa Code section 331.397A(4)"b."

25.15(3) Eligibility for intellectual disability services. An individual must comply with all of the following requirements to be eligible for intellectual disability services under the regional service system:

a. The individual complies with the financial eligibility requirements in rule 441—25.16(331).

b. The individual is at least 18 years of age.

c. The individual is a resident of this state.

d. The individual has a diagnosis of intellectual disability as defined by Iowa Code section 4.1(9A).

e. The results of a standardized functional assessment support the need for intellectual disability services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology shall be designated for intellectual services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(4) Other conditions of eligibility for intellectual disability services.

a. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

b. An individual less than 18 years of age and a resident of the state may be considered eligible for those intellectual disability services made available to all or a portion of the residents of the region of the same age and eligibility class under the county management plan of one or more counties of the region applicable prior to formation of the region. Eligibility for services under this paragraph is limited to availability of regional service system funds without limiting or reducing core services, and if part of the approved regional service system management plan.

25.15(5) Eligibility for brain injury services. An individual must comply with all of the following requirements to be eligible for brain injury services under the regional service system, if such services were provided to the same class of individuals by a county in the region prior to regional formation.

- a.* The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- b.* The individual is at least 18 years of age.
- c.* The individual is a resident of this state.
- d.* The individual has a diagnosis of brain injury as defined in rule 441—83.81(249A).
- e.* The results of a standardized functional assessment support the need for brain injury services of the type and frequency identified in the individual's case plan. The standardized functional assessment methodology used is the methodology approved for brain injury services by the director of human services in consultation with the state commission. A functional assessment must be completed within 90 days of application for services.

25.15(6) Other conditions of eligibility for brain injury services. An individual who is 17 years of age, is a resident of this state, and is receiving publicly funded children's services may be considered eligible for services through the regional service system during the three-month period preceding the individual's eighteenth birthday in order to provide a smooth transition from children's to adult services.

25.15(7) Eligibility for developmental disability services.

- a.* Until funding is designated for other service populations, eligibility for the core service domains shall be as identified in Iowa Code section 331.397(1) "b."
- b.* If a county in a region was providing services to an eligibility class of individuals with a developmental disability other than intellectual disability prior to formation of the region, the class of individuals shall remain eligible for the services provided when the region is formed, providing that funds are available to continue such services without limiting or reducing core services. The individual must also meet the requirements in paragraphs 25.15(7) "c," "d," "e" and "f."
- c.* The individual complies with the financial eligibility requirements in rule 441—25.16(331).
- d.* The individual is at least 18 years of age.
- e.* The individual is a resident of this state.
- f.* The individual has a diagnosis of a developmental disability other than an intellectual disability as defined in rule 441—24.1(225C).

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.16(331) Financial eligibility requirements. The regional service system management plan shall identify basic financial eligibility standards for mental health and disability services as defined in Iowa Code sections 331.395 and 331.396A.

25.16(1) Income requirements.

- a.* Income requirements for adult mental health and disability services shall be as follows:
 - (1) The person must have an income equal to or less than 150 percent of the federal poverty level.
 - (2) A person who is eligible for federally funded services and other support must apply for such services and support.
- b.* Income requirements for children's behavioral health services shall be as follows:

(1) The child's family has countable household income equal to or less than 500 percent of the federal poverty level. Countable household income and family size shall be determined using the modified adjusted gross income methodology.

(2) An eligible child whose family's countable household income is at least 150 percent and not more than 500 percent of the federal poverty level shall be subject to a cost share as described in subrule 25.16(3).

(3) Verification of income. Income shall be verified using the best information available.

1. Pay stubs, tip records and employers' statements are acceptable forms of verification of earned income.

2. Self-employment income can be verified through business records from the previous year if they are representative of anticipated earnings. If business records from the previous year are not representative of anticipated earnings, an average of the business records from the previous two or three years may be used if that average is representative of anticipated earnings.

(4) Changes in income. Financial eligibility shall be reviewed on an annual basis and may be reviewed more often in response to increases or decreases in income.

(5) A child who is eligible for federally funded services and other support must apply for such services and support.

25.16(2) Resource requirements. There are no resource limits for the family of a child seeking children's behavioral health services. An adult seeking mental health and disability services must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multiperson household or follow the most recent federal supplemental security income guidelines.

a. The countable value of all countable resources, both liquid and non-liquid, shall be included in the eligibility determination except as exempted in this subrule.

b. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.

c. The following resources shall be exempt:

(1) The homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources shall additionally be considered exempt from consideration in eligibility determination:

(1) A retirement account that is in the accumulation stage.

(2) A medical savings account.

(3) An assistive technology account.

(4) A burial account or trust limited in value as to that allowed in the medical assistance program.

e. An individual who is eligible for federally funded services and other support must apply for and accept such funding and support.

25.16(3) Cost-share standards. A regional administrative entity must comply with cost-share standards as defined in Iowa Code sections 331.395 and 331.396A.

a. Cost sharing is allowed for adults with income above 150 percent of the federal poverty level as defined by the most recently revised poverty guidelines published by the United States Department of Health and Human Services.

Cost-share amounts for regionally funded adult mental health and disability services in this rule are related to core services as defined in Iowa Code section 331.397 and must be identified in the enrollment and eligibility section of the region's policy and procedures approved by the department.

b. Cost-share amounts for children's behavioral health services are applicable to core services as defined in Iowa Code section 331.397A. The family of a child receiving regional funding for behavioral health services shall be responsible for a cost-share amount based on the family's household income as follows:

Family Income as a % of FPL	Cost Share % Paid by Family
0 to 150%	0%
151 to 200%	10%
201 to 250%	15%
251 to 300%	20%
301 to 350%	35%
351 to 400%	50%
401 to 450%	65%
451 to 500%	80%
Over 500%	100%

25.16(4) *Cost-share standards required by any federal, state, regional, or municipal program.* Any cost sharing or other client participation required by any federal, state, regional or municipal program in which the individual participates shall be required by the regional administrative entity. Such cost sharing includes, but is not limited to:

a. Client participation for maintenance in a residential care facility through the state supplementary assistance program.

b. The financial liability for institutional services paid by counties as provided in Iowa Code section 230.15.

c. The financial liability for attorney fees related to commitment as provided by Iowa Code section 229.8.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.17(331) Exempted counties. If a county has been exempted pursuant to Iowa Code section 331.389 from the requirement to enter into a regional service system, the county and the county's board of supervisors shall fulfill all the requirements of this chapter for a regional service system management plan.

[ARC 1173C, IAB 11/13/13, effective 1/1/14]

441—25.18(331) Annual service and budget plan. The annual service and budget plan shall describe the services to be provided and the cost of those services for the ensuing year.

25.18(1) The annual service and budget plan is due on April 1 prior to the July 1 implementation of the annual plan and shall be approved by the region's governing board prior to submittal to the department.

25.18(2) The annual service and budget plan shall include but not be limited to the following:

a. Access points. A list of the local access points for mental health and disability services and children's behavioral health services, including the names of the access points and the physical locations and contact information.

b. Service coordination and targeted case management. A list of the service coordination and targeted case management agencies utilized in the region, whether funded by the region, the medical assistance program, or third-party payers, including the physical location and contact information for those agencies.

c. Crisis planning. A list of accredited crisis services available in the region for crisis prevention, response and resolution, including contact information for the agencies responsible.

d. Intensive mental health services. Identification of the intensive mental health services designated by the region according to rule 441—25.6(331), including the provider name, contact information, and location of each of the following:

- (1) Access center(s).
- (2) ACT services.
- (3) Intensive residential services.
- (4) Subacute mental health services.

e. Children’s behavioral health services. Identification of children’s behavioral health services as described in subrule 25.2(4), including eligibility requirements or reference to where eligibility requirements can be found in the policies and procedures manual.

f. Scope of services. A description of the scope of services to be provided, a projection of need for the service, and the funding necessary to meet the need.

- (1) The scope shall include the regional core services as identified in rule 441—25.2(331).
- (2) The scope shall also include services in addition to the required core services.

g. Budget and financing provisions for the next year. The provisions shall address how county, regional, state and other funding sources will be used to meet the service needs within the region.

h. Financial forecasting measures. A description of the financial forecasting measures used in the identification of service need and funding necessary for services and a financial statement of actual revenues and actual expenses by chart of account codes, including levies by county.

i. Provider reimbursement provisions. A description of the types of provider reimbursement methods that will be used, including fee for service, compensation for a “system of care” approach, and for use of nontraditional providers. A region also shall provide information on funding approaches that identify and incorporate all services and sources of funding used by the individuals receiving services, including the medical assistance program.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.19(331) Annual service and budget plan approval. The annual service and budget plan shall be submitted each year by April 1. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the regional annual service and budget plan in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for a fiscal year beginning July 1 shall remain in effect until June 30, subject to amendment.

25.19(1) Criteria for acceptance. The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

25.19(2) Notification. Except as specified in subrule 25.19(3), the director shall notify the region in writing of the decision on the plan by June 1 of each year. The decision shall specify that either:

a. The annual service and budget plan is approved as it was submitted, either with or without supplemental information already requested and received.

b. The annual service and budget plan will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

25.19(3) Review of late submittals. The director may review plans not submitted by April 1 after all plans submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.19(4) Amendments. An amendment to the annual service and budget plan shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the plan, the director must approve the amendment.

a. **Criteria for acceptance.** The director shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the annual service and budget plan and is in compliance with all applicable state and federal

laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

b. Notification. The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will include why the amendment is not approved.

25.19(5) Reconsideration. Regions dissatisfied with the director's decision on a plan or an amendment may file a letter with the director requesting reconsideration. The letter requesting reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19]

441—25.20(331) Annual report. The annual report shall describe the services provided, the cost of those services, the number of individuals served, and the outcomes achieved for the previous fiscal year. The annual report is due on December 1 following a completed fiscal year of implementing the annual service and budget plan. The annual report shall include but not be limited to:

1. Services actually provided.
 2. The status of service development.
 3. Actual numbers of children and adults served.
 4. Documentation that each regionally designated access center has met the service standards in subrule 25.6(1).

5. Documentation that each regionally designated ACT team has been evaluated for program fidelity, including a peer review as required by subrule 25.6(2), and documentation of each team's most recent fidelity score.

6. Documentation that each regionally designated subacute service has met the service standards in subrule 25.6(7).

7. Documentation that each regionally designated intensive residential service home or intensive residential service has met the service standards in subrule 25.6(8).

8. Financial statement of actual revenues and actual expenditures by chart of account codes, including levies by county.

9. Outcomes achieved.

[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4207C, IAB 1/2/19, effective 3/1/19; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.21(331) Policies and procedures manual for the regional service system. The policies and procedures manual shall describe the policies and process developed to direct the management and administration of the regional service system. The initial manual is due on April 1, 2014, and will remain in effect subject to amendment.

25.21(1) Content. The manual shall include but not be limited to:

a. Financing and delivery of services and supports. A description of the region's process used to develop and ensure the ongoing financial accountability and delivery of services outlined in the region's annual service and budget plan shall be included.

b. Enrollment. The application and enrollment process that is readily accessible to individuals and their families or authorized representatives shall be included. This procedure shall identify regional access points and where individuals can apply for services and how and when the applications will reach the regional administrative entity's designated staff for processing.

c. Eligibility. The process utilized to determine eligibility shall be included in the manual and shall include but not be limited to:

(1) The criteria used to authorize or deny funding for services and supports. This shall include guidelines for who is eligible to receive services and supports by eligibility group, and type of service or support.

(2) Financial eligibility and copayment criteria, which shall meet the requirements of rule 441—25.16(331).

(3) The time frames for conducting eligibility determination that provide for timely access to services, including necessary and immediate services not to exceed ten days.

(4) The process for development of a written notice of decision. The time frame for sending a written notice of decision to the individual and guardian (if applicable) and the service providers identified in the notice shall be included. The notice of decision shall:

1. Explain the action taken on the application and the reasons for that action.
2. State what services are approved and name the service providers.
3. Outline the individual's right to appeal.
4. Describe the appeal process.

d. Utilization of and access to services. The process for managing utilization of and access to services and other assistance shall be included. The process shall describe how coordination between the services included in the annual service and budget plan and the disability services administered by the state and others will be managed.

e. Quality management and improvement process. The quality management and improvement process shall at a minimum meet the requirements of the department's outcome and performance measures process as outlined in Iowa Code sections 225C.4(1) "j" and 225C.6A.

f. Risk management and fiscal viability. If the region contracts with a private entity, the manual must include risk management provisions and fiscal viability of the annual services and budget plan.

g. Targeted case management.

(1) Designation of targeted case management providers. The process used to identify and designate targeted case management providers for the region shall be described. This process shall include the requirement for the implementation of evidence-based practice models of case management within the region. Requirements of this practice include:

1. Providing the individual receiving the case management with a choice of providers.
2. Allowing a service provider to be the case manager but prohibiting the provider from referring that individual only to services administered by the provider.
3. Provisions to ensure compliance with, but not exceed, federal requirements for conflict-free case management.

(2) Qualifications of targeted case managers. A region's manual shall require that any targeted case managers or other persons providing service coordination while working for the designated provider meet the qualifications of qualified case managers and supervisors as defined in rule 441—24.1(225C).

(3) Targeted case management and service coordination services. Targeted case management and service coordination services utilized in a regional service system shall include but are not limited to the following as defined in Iowa Code section 331.393(4) "g":

1. Performance and outcome measures relating to the health, safety, school attendance and performance, work performance, and community residency of the individuals receiving the services.

2. Standards for delivery of the services, including but not limited to the social history, assessment, service planning, incident reporting, crisis planning, coordination, and monitoring for individuals receiving the services.

3. Methodologies for complying with the requirements of paragraph 25.21(1) "g." Methodologies may include the use of electronic record keeping and remote or Internet-based training.

h. System of care approach plan.

i. Decentralized service provision. Measures to provide services in a dispersed manner that meet the minimum access standards of core services and that utilize the strengths and assets of the service providers within and available to the region shall be included.

j. Provider network formation and management. The manual shall require that providers that are subject to license, accreditation or approval meet established standards. The manual shall detail the

approval process, including criteria, developed to select providers that are not currently subject to license, accreditation or approval standards. The manual shall identify the process the regional administrative entity will use to contract with providers and manage the provider network to ensure it meets the needs of the individuals in the region. The provider network will include but is not limited to the following:

(1) A contract with a community mental health center that provides services in the individual's region or with a federally qualified health center that provides psychiatric and outpatient mental health services in the individual's region.

(2) Contracts with licensed and accredited providers to provide each service in the required core service domains.

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

(4) A contract with an inpatient psychiatric hospital unit or state mental health institute within reasonably close proximity.

k. Service provider payment provisions. A policy for payment of service providers which describes the method and process of paying for services and supports delivered to the region shall be included.

l. Grievance processes. The manual shall develop and implement processes for appealing the decisions of the regional administrative entity in the following circumstances:

(1) Nonexpedited appeal process. The appeal process shall be based on objective criteria, specify time frames, provide for notification in accessible formats of the decisions to all parties, and provide some assistance to individuals with disabilities using the process. Responsibility for the final step in the appeal process shall be a state administrative law judge in nonexpedited appeals.

(2) Expedited appeal process. This appeal process is to be used when the decision of the regional administrative entity concerning an individual varies from the type and amount of service identified to be necessary for the individual in a clinical determination made by a mental health professional and the mental health professional believes that the failure to provide the type and amount of service identified could cause an immediate danger to an individual's health or safety. This appeal process shall be performed by a mental health professional who is either the administrator of the division of mental health and disability services of the department of human services or the administrator's designee.

1. The appeal shall be filed within five days of receipt of the notice of decision by the regional administrative entity.

2. The expedited review by the division administrator or designee shall take place within two days of receipt of the request, unless more information is needed. There is an extension of two days from the time the new information is received.

3. The administrator shall issue an order, including a brief statement of findings of fact, conclusions of law, and policy reasons for the order, to justify the decision made concerning the expedited review. If the decision concurs with the contention that there is an immediate danger to the individual's health or safety, the order shall identify the type and amount of service which shall be provided for the individual. The administrator or designee shall give such notice as is practicable to individuals who are required to comply with the order. The order is effective when issued.

4. The decision of the administrator or designee shall be considered a final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

m. Implementation of interagency and multisystem collaboration and care coordination. The policies and procedures manual shall describe how the region will collaborate with other funders, other regional service systems, service providers, case management, individuals and their families or authorized representatives, and advocates to ensure that authorized services and supports are responsive to individuals' needs, consistent with system principles, and cost-efficient. The manual shall describe the process for collaboration with the court to ensure alternatives to commitment and to coordinate funding for services to individuals who are under court-ordered commitment services pursuant to Iowa Code chapter 229.

n. Addressing multioccurring needs. The policies and procedures manual shall include criteria and measures to be used to address the needs of individuals who have two or more co-occurring mental health,

intellectual or other developmental disability, brain injury, or substance-related disorders. The manual shall also include criteria and measures to be used to address the needs of individuals with specialized needs.

o. Service management and functional assessment. The policies and procedures manual shall describe how functional assessments and service management will be incorporated in accordance with applicable requirements.

p. Service system management. The policies and procedures manual shall identify whether the region will be directly implementing a system of service management or will contract with a private entity to manage the regional service system. If the region contracts with a private entity, the region will ensure that all requirements of Iowa Code section 331.393 and these administrative rules are fulfilled.

q. Assistance to other than core service populations. The policies and procedures manual shall specify the services populations, other than core service populations, to whom the region will provide assistance if funding is available.

r. Waiting list criteria. The policies and procedures manual shall specify whether the region will use waiting lists. If the policy and procedures manual specifies the use of waiting lists for funding services and supports, it shall specify criteria for the use and review of each waiting list, including the criteria to be used to determine how and when an individual will be placed on a waiting list. The criteria will include how core services and additional core services will be impacted the least by budgetary limitations. The manual shall specify how waiting list data will be used in future planning.

25.21(2) Approval. The manual shall be submitted by April 1, 2014, as a part of the region's management plan for the fiscal year beginning July 1, 2014. The manual shall be approved by the region's governing board and is subject to approval by the director of human services. The director shall review all regional annual service and budget plans submitted by the dates specified. If the director finds the manual in compliance with these rules and state and federal laws, the director may approve the plan. A plan approved by the director for the fiscal year beginning July 1, 2014, shall remain in effect subject to amendment.

a. Criteria for acceptance. The director shall determine a plan is acceptable when it contains all the required information, meets the criteria described in this division, and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the plan contains all the required information and meets criteria described in this division.

b. Notification.

(1) Except as specified in subparagraph 25.21(2) "b"(2), the director shall notify the region in writing of the decision on the plan by June 1, 2014. The decision shall specify that either:

1. The policies and procedures manual is approved as it was submitted, either with or without supplemental information already requested and received.

2. The policies and procedures manual will not be approved until revisions are made. The letter will specify the nature of the revisions requested and the time frames for their submission.

(2) Review of late submittals. The director may review manuals not submitted by April 1, 2014, after all manuals submitted by that date have been reviewed. The director will proceed with the late submittals in a timely manner.

25.21(3) Amendments. An amendment to the policy and procedures manual shall be approved by the regional governance board and submitted to the department at least 45 days before the date of implementation. Before implementation of any amendment to the manual, the director must approve the amendment.

a. Criteria for acceptance. The director, in consultation with the state commission, shall determine an amendment is acceptable when it contains all the required information and meets the criteria described in this division for the applicable part of the policy and procedures manual and is in compliance with all applicable state and federal laws. The director may request additional information to determine whether or not the amendment contains all the required information and meets criteria described in this division.

b. Notification. The director shall notify the region, in writing, of the decision on the amendment within 45 days of receipt of the amendment. The decision shall specify either that:

(1) The amendment is approved as it was submitted, either with or without supplemental information already requested and received.

(2) The amendment is not approved. The notification will explain why the amendment is not approved.

25.21(4) Reconsideration. Regions dissatisfied with the director's decision on a manual or an amendment may file a letter with the director requesting reconsideration. The letter of reconsideration must be received within 30 working days of the date of the notice of decision and shall include a request for the director to review the decision and the reasons for dissatisfaction. Within 30 working days of the receipt of the letter requesting reconsideration, the director will review both the reconsideration request and evidence provided. The director shall issue a final decision in writing.

These rules are intended to implement Iowa Code sections 331.388 to 331.398.
[ARC 1173C, IAB 11/13/13, effective 1/1/14; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.22(225C) Incentive fund application, approval, and reporting.

25.22(1) Application for regional incentive funds. A mental health and disability services region must submit an application on forms specified by the department with required supporting documentation. An application to receive regional incentive funds must meet the following requirements:

- a. The region shall submit the application with supporting documentation electronically to the department by 4:30 p.m. on November 15 of the state fiscal year in which funding is requested.
- b. The application shall be complete and signed by the chairperson of the regional governing board and regional chief executive officer.
- c. Application supporting documentation shall include evidence to demonstrate compliance with subrule 25.22(2).

25.22(2) Applicant conditions. To receive funding, a region must submit to the department sufficient data to demonstrate that the region has met the standards in the region's performance-based contract outlined in rule 441—25.23(331). Additionally, the region must meet the following conditions:

- a. The region must be in compliance with the regional service system management plan as defined in Iowa Code section 331.393.
- b. The region's ending fund balance in the fiscal year that commenced two years prior to the year of application shall meet the ending balance threshold in accordance with Iowa Code section 225C.7A.
- c. The region must need incentive funds for one or more of the following circumstances:
 - (1) If the region has an operating deficit, to reimburse the region for a reduction in available funding for core services as the result of the reduction and elimination of the levy.
 - (2) To incentivize quality core services that meet or exceed the defined outcomes in the performance-based contract.
 - (3) To support regional efforts to fund non-core services that support the defined outcomes of core services in the performance-based contract.
 - (4) For support of non-core services to maintain individuals in a community setting or reduce the risk that individuals needing services and supports would be placed in more restrictive, higher-cost settings.

25.22(3) Incentive fund application review and approval. The department shall make its final decisions for incentive funds on or before December 15 of the fiscal year of application.

- a. A written notice regarding acceptance or rejection of an application and the total amount obligated shall be furnished to the mental health and disability services region.
- b. The department shall distribute incentive funds payable to the mental health and disability services regions for the amounts due on or before January 1.

25.22(4) Incentive fund reporting. Mental health and disability services regions shall submit to the department a report on forms specified by the department twice each calendar year subsequent to an award distribution. Reports shall be submitted by February 15 and August 15.

25.22(5) Incentive fund review. The department shall analyze year-end financial records and annual independent audits of the mental health and disability services region for all years subsequent to an

incentive fund award. If the department determines a mental health and disability services region's actual need for incentive funds was less than the amount of incentive funds granted, the mental health and disability services region shall refund the difference between the amount of assistance granted and the actual need.

a. A written notice outlining the department's findings and moneys identified for repayment shall be furnished to the regional administrative entity.

b. The mental health and disability services region shall submit the refund within 30 days of receiving notice from the department. Refunds shall be credited to the incentive fund.

This rule is intended to implement Iowa Code section 225C.7A.

[ARC 6008C, IAB 11/3/21, effective 10/4/21; ARC 6195C, IAB 2/9/22, effective 3/16/22; ARC 6237C, IAB 3/9/22, effective 5/1/22]

441—25.23(331) Performance-based contract. The mental health and disability services region shall enter into a performance-based contract with the department to administer the service system in accordance with Iowa Code section 225C.7A. The performance-based contract shall include but not be limited to the following requirements:

25.23(1) The department will approve, deny, or revise each region's annual service and budget plan in accordance with rule 441—25.19(331).

25.23(2) The region will provide access to all core services under Iowa Code sections 331.397 and 331.397A and in accordance with this chapter.

25.23(3) The region will utilize all federal government funding, including Medicaid funding, third-party payment sources, and other nongovernmental funding, prior to using regional service payments.

25.23(4) The department will perform an annual review of the region's administrative costs.

25.23(5) The department will establish outcome improvement goals for populations served by the region, including but not limited to:

a. Decreases in emergency department visits.

b. Improved use of mobile crisis response and jail diversion programs.

c. Improved employment-based outcomes.

25.23(6) The department will take steps to address a region's noncompliance with the contract in accordance with Iowa Code section 331.389.

This rule is intended to implement Iowa Code section 225C.7A.

[ARC 6237C, IAB 3/9/22, effective 5/1/22]

441—25.24 to 25.40 Reserved.

DIVISION III
MINIMUM DATA SET

441—25.41(331) Minimum data set. Each county shall maintain data on all clients served through the MH/DD services fund.

25.41(1) *Submission of data.* Each county shall submit to DHS a copy of the data regarding each individual that the county serves through the central point of coordination process.

a. DHS state payment program, state supplementary assistance program, mental health institutes, state resource centers, Medicaid program, and Medicaid managed care contractors shall provide the equivalent data in a compatible format on the same schedule as the required submission from the counties.

b. DHS shall maintain the data in the data analysis unit for research and analysis purposes only. Only summary data shall be reported to policymakers or the public.

25.41(2) *Data required.* The data to be submitted are as follows:

a. Basic client information including a unique identifier, name, address, county of residence and county of legal settlement.

b. The state I.D. number for state payment cases.

c. Demographic information including date of birth, sex, ethnicity, marital status, education, residential living arrangement, current employment status, monthly income, income sources, type of

insurance, insurance carrier, veterans' status, guardianship status, legal status in the system, source of referral, diagnosis in the current version of the DSM, diagnosis in the current version of the ICD, disability group (i.e., intellectual disability, developmental disability, chronic mental illness, mental illness), central point of coordination (county number preceded by A 1), and central point of coordination (CPC) name.

d. Service information including the decision on services, date of decision, date client terminated from CPC services and reason for termination, residence, approved service, service beginning dates, service ending dates, reason for terminating each service, approved units of services, unit rate for service, expenditure data, and provider data.

e. Counties shall not be penalized in any fashion for failing to collect data elements in situations of crisis or in outreach efforts to identify or engage people in needed mental health services. For the purposes of this rule:

(1) Situations of crisis include but are not limited to voluntary and involuntary hospitalizations, legal and transportation services associated with involuntary hospitalizations, emergency outpatient services, mobile crisis team services, jail diversion services, mental health services provided in a county jail, and other services for which the county is required to pay but does not have access to the client to collect the required information.

(2) Outreach efforts to identify or engage people in needed mental health services include but are not limited to mental health advocate services; services for homeless persons, refugees, or other legal immigrants; services for state cases who do not have documentation with them and are unable to help the county locate appropriate records; consultation; education to raise public awareness; 12-step or other support groups for persons with dual disorders; and drop-in centers.

f. Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 100 percent reporting of the data elements listed in this paragraph. Beginning with the data reported for state fiscal year 2008, less than 100 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph "e":

- (1) Client identifiers:
 1. Lname3 (the first three letters of the client's last name).
 2. Last4SSN (the last four digits of the client's social security number).
 3. SEX (the client's sex).
 4. BDATE (the client's birth date).
- (2) CPC (central point of coordination).
- (3) Payment information:
 1. PYMTDATE (CoMIS payment date).
 2. FUND CODE (CoMIS fund code).
 3. DG (CoMIS diagnosis).
 4. COACODE (CoMIS chart of accounts code).
 5. BEGDATE (CoMIS service beginning date).
 6. ENDDATE (CoMIS service ending date).
 7. UNITS (CoMIS units of service).
 8. COPD (CoMIS county paid).
- (4) ValidSSN (valid social security number indicator).
- (5) IsPerson (IsPerson indicator).

g. Although all of the data in the minimum data set are important to provide support for program analysis, a county shall be penalized for noncompliance with this rule if the county does not provide 90 percent reporting of the data elements listed in this paragraph beginning with the data reported for fiscal year 2008. Less than 90 percent reporting for the following items shall be viewed as noncompliance unless the data are exempted by paragraph "e":

- (1) Application Date (application date).
- (2) RESCO (residence county).
- (3) LEGCO (legal county).

(4) Provider ID (vendor number).

h. The department shall analyze the data received on or before December 1 each year by December 15 or by the next business day if December 15 falls on a weekend or holiday.

(1) When a county’s data submission does not meet the specifications in paragraph “f” or “g,” the department will notify the county by email.

(2) The county shall have 30 days from the date of the email notice to submit the missing data or to provide an explanation of why the data cannot be reported.

(3) If the county does not report the data or provide an adequate explanation within 30 days, the department shall find the county in noncompliance.

i. The department shall post the aggregate reports received by December 1 on the department’s website within 90 days.

25.41(3) Method of data collection. A county may choose to collect this information using the county management information system (CoMIS) that was designed by the department or may collect the information through some other means. If a county chooses to use another system, the county must be capable of supplying the information in the same format as CoMIS.

a. Except as provided in subparagraph (3), each county shall submit the following files in Microsoft Excel format (version 97 to 2000) or comma-delimited text file (CSV) format using data from the associated CoMIS table or from the county’s chosen management information system:

<u>Files to submit</u>	<u>Associated CoMIS Table</u>
WarehouseClient.xls or WarehouseClient.csv	Client Data
WarehouseIncome.xls or WarehouseIncome.csv	Income Review
WarehousePayment.xls or WarehousePayment.csv	Payment
WarehouseProvider.xls or WarehouseProvider.csv	Provider
WarehouseProviderServices.xls or WarehouseProviderServices.csv	tblProviderServices
WarehouseService.xls or WarehouseService.csv	Service Authorizations

(1) Paragraphs “b” through “g” list the data required in each file and specify the structure or description for each data item to be reported.

(2) The field names used in the report files must be exactly the same as indicated in the corresponding paragraph, including spaces, and must be entered in the first row for each sheet.

(3) The file labeled WarehouseService.xls or WarehouseService.csv or service authorization (described in paragraph “g” of this subrule) shall be removed from this requirement on June 30, 2011, if data from this file have not been used by that date.

b. File name: WarehouseClient.xls or WarehouseClient.csv.

Sheet name: Warehouse_Client_Transfer_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa

Field Name	Data Type	Field Size	Format	Description
				900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
Last Update	Date	10	mm/dd/yyyy	Date of last update to client record
SID	Text	8	9999999a	State identification number of client, if applicable (format of a valid number is 7 digits plus 1 alphabetical character).
ADD1	Text	50		First address line
ADD2	Text	50		Second address line (if applicable)
CITY	Text	50		City address line
STATE	Text	2		State code
ZIP	Number	5	0 decimal places	5-digit ZIP code
ETHN	Number	1	0 decimal places	Ethnicity of client: 0 = Unknown 1 = White, not Hispanic 2 = African-American, not Hispanic 3 = American Indian or Alaskan native 4 = Asian or Pacific Islander 5 = Hispanic 6 = Other (biracial; Sudanese; etc.)
MARITAL	Number	1	0 decimal places	Marital status of client: 1 = Single, never married 2 = Married (includes common-law marriage) 3 = Divorced 4 = Separated 5 = Widowed
EDUC	Number	2	0 decimal places	Education level of the client
RARG	Number	2	0 decimal places	Residential arrangement of client: 1 = Private residence/household 2 = State MHI 3 = State resource center 4 = Community supervised living 5 = Foster care or family life home 6 = Residential care facility 7 = RCF/MR 8 = RCF/PMI 9 = Intermediate care facility 10 = ICF/MR 11 = ICF/PMI 12 = Correctional facility 13 = Homeless shelter or street 14 = Other
LARG	Number	1	0 decimal places	Living arrangement of client: 1 = Lives alone 2 = Lives with relatives 3 = Lives with persons unrelated to client

Field Name	Data Type	Field Size	Format	Description
INS	Number	1	0 decimal places	Health insurance owned by client: 1 = Client pays 3 = Medicaid 4 = Medicare 5 = Private third party 6 = Not insured 7 = Medically Needy
INSCAR	Text	50		First insurance company name, if applicable
INSCAR1	Text	50		Second insurance company name, if applicable
INSCAR2	Text	50		Third insurance company name, if applicable
VET	Text	1		Veteran status of client: Y = Yes N = No
CONSERVATOR	Number	1	0 decimal places	Conservator status of client: 1 = Self 2 = Other
GUARDIAN	Number	1	0 decimal places	Guardian status of client: 1 = Self 2 = Other
LEGSTAT	Number	1	0 decimal places	Legal status of client: 1 = Voluntary 2 = Involuntary, civil commitment 3 = Involuntary, criminal commitment
REFSO	Number	1	0 decimal places	Referral source of client: 1 = Self 2 = Family or friend 3 = Targeted case management 4 = Other case management 5 = Community corrections 6 = Social service agency other than case management 7 = Other
DSM (current version)	Text	50		DSM (current version) diagnosis code of client
ICD (current version)	Text	50		ICD (current version) diagnosis code (optional for county use; not tied to CoMIS entry)
DG	Number	2	0 decimal places	Disability group of client: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
Application Date	Date	10	mm/dd/yyyy	Date of client's initial application
Outcome decision	Number	1	0 decimal places	Decision on client's application: 1 = Application accepted 2 = Application denied 3 = Decision pending
Decision date	Date	10	mm/dd/yyyy	Date decision was made on client's application

Field Name	Data Type	Field Size	Format	Description
Denial reason	Text	2		Denial reason code: 00 = Not applicable 01 = Over income guidelines 1A = Over resource guidelines 02 = Does not meet county plan criteria 2A = Legal settlement in another county 2B = State case 3A = Brain injury 3B = Alzheimer's 3C = Substance abuse 3D = Other 04 = Does not meet service plan criteria 05 = Client desires to discontinue process 5A = Client fails to return requested information
Client exit date from CPC	Date	10	mm/dd/yyyy	Date client was terminated from CPC services
Exit reason	Number	1	0 decimal places	Reason client left the CPC system: 0 = Unknown 1 = Client voluntarily withdrew 2 = Client deceased 3 = Unable to locate consumer 4 = Ineligible due to reasons other than income 5 = Ineligible, over income guidelines 6 = Client moved out of state 7 = Client no longer needs service 8 = Client has legal settlement in another county
Review Date	Date	10	mm/dd/yyyy	Date of last application review
PhoneNumber	Text	50		Phone number of client
ValidSSN	Text	3	Generated for CoMIS users in the data extract only	Populate this field with YES if the client has a valid social security number. If the client does not have a valid social security number, populate this field with NO.
IsPerson	Text	3	Generated for CoMIS users in the data extract only	Populate this field with YES if the client is a person. If the client entry represents a nonperson such as administrative costs, populate this field with NO.

c. File name: WarehouseIncome.xls or WarehouseIncome.csv.

Sheet name: Warehouse_Income_Transfer_Query.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth

Field Name	Data Type	Field Size	Format	Description
SEX	Text	1		Sex of client: M = Male F = Female
EMPL	Number	2	0 decimal places	Employment situation of client: 1 = Unemployed, available for work 2 = Unemployed, unavailable for work 3 = Employed full-time 4 = Employed part-time 5 = Retired 6 = Student 7 = Work activity employment 8 = Sheltered work employment 9 = Supported employment 10 = Vocational rehabilitation 11 = Seasonally employed 12 = In the armed forces 13 = Homemaker 14 = Other or not applicable 15 = Volunteer
House Hold Size	Number	2	0 decimal places	Number of people in client's household
INCSOUR	Number	2	0 decimal places	Primary income source of client: 1 = Family and friends 2 = Private relief agency 3 = Social security disability benefits 4 = Supplemental Security Income 5 = Social security benefits 6 = Pension 7 = Food assistance 8 = Veterans benefits 9 = Workers compensation 10 = General assistance 11 = Family investment program (FIP) 12 = Wages
Public Assistance Payments	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Social Security Disability	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
SSI	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
VA Benefits	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
R/R Pension	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Child Support	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Employment Wages	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Dividend Interest	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Other Income	Currency	14	2 decimal places	Monthly dollar amount for this income source (where applicable)
Description 1	Text	50		Description of "Other Income"
Cash on hand	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Checking	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Savings	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)

Field Name	Data Type	Field Size	Format	Description
Stocks/Bonds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Time Certificates	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Trust Funds	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Other Resources	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 2	Text	50		Description of "Other Resources" (where applicable)
Other Resources 2	Currency	14	2 decimal places	Dollar amount for this resource type (where applicable)
Description 3	Text	50		Description of "Other Resources 2"
Date reviewed	Date	10	mm/dd/yyyy	Date income was last reviewed (where applicable)

d. File name: WarehousePayment.xls or WarehousePayment.csv. Sheet name: Warehouse_Payment_Transfer_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female
PYMTDATE	Date	10	mm/dd/yyyy	Date county approves or makes payment
VENNAME	Text	50		Vendor or provider paid
COCODE	Number	3	0 decimal places	County where service was provided
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for payment
BEGDATE	Date	10	mm/dd/yyyy	Beginning date of payment period
ENDDATE	Date	10	mm/dd/yyyy	Ending date of payment period
UNITS	Number	4	0 decimal places	Number of service units for payment
COPD	Currency	14	2 decimal places	Amount paid by the county
RECEIVED	Currency	14	2 decimal places	Amount received for reimbursement (if applicable)

e. File name: WarehouseProvider.xls or WarehouseProvider.csv. Sheet name: Warehouse_Provider_Transfer_Que. (If the provider has more than one office location, enter information for the headquarters office.)

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
Provider Address1	Text	50		Provider address line 1
Provider Address2	Text	50		Provider address line 2 (if applicable)
City	Text	50		Provider city
State	Text	2		Provider state code
Zip	Text	10		Provider ZIP code
COCODE	Number	3	0 decimal places	Provider county code
PhoneNumber	Text	50		Provider phone number
Date of Last Update	Date	10	mm/dd/yyyy	Provider last updated date

f. File name: WarehouseProviderServices.xls or WarehouseProviderServices.csv. Sheet name: Warehouse_Provider_Services_Tra.

Field Name	Data Type	Field Size	Format	Description
Provider ID	Text	50		Provider identifier (tax ID code)
Provider Name	Text	50		Provider name
FUND CODE	Text	10		Fund code for payment
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other categories
COACODE	Number	5	0 decimal places	Chart of accounts code for service
RATE	Currency	14	2 decimal places	Payment rate

g. File name: WarehouseService.xls or WarehouseService.csv. Sheet name: Warehouse_Service_Transfer_Quer.

Field Name	Data Type	Field Size	Format	Description
CPC	Number	3	0 decimal places	Central point of coordination number: county number preceded by a 1
RESCO	Number	3	0 decimal places	Residence county of client: 1-99 = County number 100 = State of Iowa 900 = Undetermined or in dispute
LEGCO	Number	3	0 decimal places	Legal county of client: 1-99 = County number 100 = State of Iowa 200 = Iowa nonresident 900 = Undetermined or in dispute
Lname3	Text	3		The first 3 characters of the last name
Last4SSN	Text	4		The last 4 digits of the client's social security number. If that number is unknown, then use the last 4 digits of the CLIENT ID# field and mark column "ValidSSN" with the value "No."
BDATE	Date	10	mm/dd/yyyy	Date of client's birth
SEX	Text	1		Sex of client: M = Male F = Female

Field Name	Data Type	Field Size	Format	Description
FUND CODE	Text	10		Fund code for service
DG	Number	2	0 decimal places	Disability group code for payment: 40 = Mental illness 41 = Chronic mental illness 42 = Mental retardation 43 = Other developmental disability 44 = Other category
COACODE	Number	5	0 decimal places	Chart of accounts code for service
Begin Date	Date	10	mm/dd/yyyy	Beginning date of service period
End Date	Date	10	mm/dd/yyyy	Ending date of service period
Ending Reason	Number	1	0 decimal places	Reason for terminating approval of service: 0 = NA 1 = Voluntary withdrawal 2 = Client no longer needs service 3 = Ineligible, over income guidelines 4 = Ineligible due to other than income 5 = Client moved out of state 6 = Client deceased 7 = Reauthorization
Units	Number	4	0 decimal places	Average number of service units approved monthly
Rate	Currency	14	2 decimal places	Dollar amount per service unit
Review Date	Date	10	mm/dd/yyyy	Date for next service review

This rule is intended to implement Iowa Code sections 331.438 and 331.439.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—25.42 to 25.50 Reserved.

DIVISION IV
MENTAL HEALTH ADVOCATES
PREAMBLE

This division establishes definitions, appointment and qualifications, assignment, responsibilities of the advocate and the county, data collection requirements, and quality assurance for mental health advocate services under Iowa Code chapter 229.

[ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.51(229) Definitions.

“*Advocate*” means mental health advocate as defined in Iowa Code section 229.1.

“*Conflict of interest*” means any activity that interferes or gives the appearance of interference with the exercise of professional discretion and impartial judgment.

“*County of residence*” means the same as defined in Iowa Code section 331.394.

“*County of venue*” means the county in which the Iowa Code chapter 229 commitment was filed pursuant to Iowa Code section 229.44.

“*County where the individual is located*” means the individual’s county of residence as defined in Iowa Code section 331.394, or if the individual has been ordered to receive treatment services under an Iowa Code chapter 229 commitment and is placed in a residential or other treatment facility.

“*Individual*” means the respondent who is receiving mental health advocate services under Iowa Code chapter 229.

“*Judicial district*” means the same as defined in Iowa Code section 602.6107.

“*Mental health and disability services region*” means the same as defined in Iowa Code section 331.389.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.52(229) Advocate appointment and qualifications. The board of supervisors of each county shall appoint a person to act as an advocate representing the interests of individuals involuntarily

hospitalized by the court under Iowa Code chapter 229. The advocate is hired by the board of supervisors and employed by the county.

25.52(1) A person may be appointed and employed or contracted with as the advocate by one county or by multiple counties. Advocates may be appointed for counties in more than one judicial district or more than one mental health and disability services region.

25.52(2) Qualifications.

a. The advocate shall meet the following qualifications:

(1) Possess a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to persons with mental illness; or

(2) Hold an Iowa license to practice as a registered nurse and have at least three years of experience in delivery of services to persons with mental illness.

b. A person employed as an advocate on or before July 1, 2015, who does not meet the requirements of subparagraph 25.52(2) "a" (1) or (2) shall be considered to meet those requirements so long as the person is continuously appointed as an advocate in the employing county.

c. A person employed as an advocate must pass criminal background, sex offender registry, and child and dependent adult abuse registry checks before hire.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.53(229) Advocate assignment. The committing court shall assign the advocate from the county where the individual is located.

25.53(1) If the advocate assigned cannot serve the individual in an effective and efficient manner, the advocate may request another advocate to perform advocate duties on the individual's behalf. In the event that another advocate can better represent the individual on a longer term basis, the advocate shall request that the court transfer the individual to another advocate.

25.53(2) When a conflict of interest is identified between an advocate and an individual, the court and the advocate's county of employment shall be notified and an alternative advocate shall be assigned. The advocate's direct supervisor is responsible to monitor and ensure that the advocate does not have a conflict of interest. In instances when dual or multiple relationships are unavoidable, advocates should take steps to protect individuals and are responsible for setting clear, appropriate, and culturally sensitive boundaries. Advocates who anticipate a conflict of interest among the individuals receiving services should clarify the advocate's role with the parties involved and take appropriate action to minimize any conflict of interest.

25.53(3) When the advocate assigned is not the advocate from the individual's county of residence, the advocate's county of employment may seek reimbursement from the region in which the individual's county of residence is located as outlined in Iowa Code section 229.19(1) "b."

25.53(4) An advocate shall only be assigned to a child 17 years of age or under when the child is not represented by an attorney due to an existing child in need of assistance (CINA) or other juvenile court action pursuant to the Iowa Code.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.54(229) Advocate responsibilities. The minimum duties of the advocate are outlined in Iowa Code section 229.19. The role of the advocate is to ensure that the rights of the individual are upheld.

25.54(1) The advocate shall be readily accessible to communication from the individual and shall initiate contact within 5 days of the individual's commitment. The advocate shall inform the individual regarding the role of the advocate.

25.54(2) The advocate shall meet the individual in person within 15 days of the individual's commitment. The advocate shall present the county grievance procedure process, in writing, to the individual. The presentation shall include the county grievance procedure and contact information and the contact information for the ombudsman. The advocate shall inform the individual about the mental health crisis services that are available.

25.54(3) The advocate shall review each report submitted to the court and communicate with the individual's medical and treatment team. Advocates shall abide by all federal, state, and local confidentiality laws.

25.54(4) The advocate shall file with the court Iowa Ct. R. 12.36—Form 30, quarterly reports for each individual assigned to the advocate. The report shall state the actions taken with the individual and amount of time spent on behalf of the individual.

25.54(5) The advocate shall maintain an organized confidential and secure file for each individual served. The file shall contain but not be limited to:

- a. Copies of quarterly reports submitted to the court.
- b. Copies of correspondence sent to and received from the individual, family members, providers and others.
- c. Releases of information.
- d. Case notes describing the date, time and type of contact with the individuals or others and a brief narrative summary of the content or outcome of the contact.
- e. Documents filed with the court electronically shall be considered as part of the individual's file.

25.54(6) The advocate shall register as provided in Iowa Ct. R. 16.305(1) to participate in the court's electronic document management system and shall submit all documents to be filed with the court electronically. The documents will be stored as electronic records that are retrievable and readable through the electronic document management system.

25.54(7) The advocate, as an employee of the county, shall comply with all county policies and procedures, including but not limited to hiring, supervision, grievance procedures, and training.

25.54(8) All advocate records are the property of the county, which is responsible for the provision of confidential storage, transfer, and destruction of client files, including those maintained on electronic and digital devices, with access limited according to the county's policy on confidentiality as described in subrule 25.55(6).

25.54(9) The advocate may attend the hospitalization hearing of an individual represented by an attorney; however, payment for the advocate's attendance is at the discretion of the county of employment.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.55(229) County responsibilities. As the employer of the advocate, the county shall provide qualified staff to support and facilitate the provision of quality advocate services. The county shall:

25.55(1) Assign a single supervisor, a single contract manager, or the county board of supervisors as the supervising entity to carry out responsibilities in this chapter.

25.55(2) Have a job description in the personnel file of the advocate that clearly defines the advocate's responsibilities and qualifications as defined in Iowa Code section 229.19 and in rule 441—25.104(229).

25.55(3) Have a process to verify, within 90 days of the advocate's hire, qualification of the advocate, including degrees and certifications obtained from a primary source.

25.55(4) Provide to the advocate training and education relevant to the position, including but not limited to overview of mental health diagnosis and treatment, the mental health and disability services delivery system, confidentiality, individual rights, professional conduct, the role of advocacy and service coordination within an interdisciplinary team, Iowa Code and administrative rules, and court procedures.

25.55(5) Provide approved training on child and dependent adult abuse reporter requirements.

25.55(6) Provide to any employee with access to individuals' files training on state and federal laws regarding nondisclosure and confidentiality of client protected health information during and after employment and maintain in the personnel files a signed document indicating the employee's awareness of the county's policy on confidentiality.

25.55(7) Complete criminal background, sex offender registry and child and dependent adult abuse registry checks before employment of the advocate. Any person who does not pass these checks is prohibited from being hired, or continuing to serve, as an advocate.

25.55(8) Provide advocate staff to cover the county's caseload at all times, according to, but not limited to, each county's unique number of individuals assigned to the advocate, travel required, types of settings where the individuals reside, services available and extended staff absences.
 [ARC 2438C, IAB 3/16/16, effective 5/1/16; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.56(229) Data collection requirements.

25.56(1) Beginning in 2016 and by December 1 each year, each county shall submit to the department of human services data regarding each individual who received advocate services during the previous state fiscal year.

25.56(2) As defined in rule 441—25.41(331), the data to be submitted are as follows:

- a. Basic information about the individual, including a unique identifier and county of residence.
- b. Demographic information, including the individual's date of birth, sex, ethnicity, education, and diagnosis made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA).
- c. Commitment information, including the date of the individual's initial commitment, type of commitment order, whether a juvenile or adult case, date of commitment and name of treatment facility the individual is committed to, any subsequent changes in treatment facility, and date commitment is terminated.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; see Delay note at end of chapter; ARC 4896C, IAB 2/12/20, effective 3/18/20]

441—25.57(229) Quality assurance system. The county shall implement a quality assurance system which:

1. Annually measures and assesses advocates' activities and services.
2. Gathers feedback from stakeholders including individuals using advocate services, family members, court staff, service provider staff, and regional staff regarding advocate services.
3. Implements an internal review of individual records.
4. Identifies areas in need of improvement.
5. Develops a plan to address the areas in need of improvement.
6. Implements the plan and documents the results.

[ARC 2438C, IAB 3/16/16, effective 5/1/16; ARC 4896C, IAB 2/12/20, effective 3/18/20]

These rules are intended to implement Iowa Code chapter 229.

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¹ Two ARCs

² May 1, 2016, effective date of 25.106 (ARC 2438C) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 8, 2016. At its meeting held June 14, 2016, the Committee delayed the effective date of 25.106 until the adjournment of the 2017 Session of the General Assembly.

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES

[Prior to 8/18/82, Mental Health Advisory Council[566] Ch 2]

[Prior to 7/1/83, Social Services[770] Ch 34]

[Prior to 2/11/87, Human Services[498]]

441—34.1(225C) Definitions. Unless otherwise indicated, the following definitions shall apply to the specific terms used in these rules:

“*Alternative diagnostic facility*” means any organization or individual designated by the county board of supervisors to implement the preliminary diagnostic evaluation policy (Iowa Code section 225C.14) when a county is not served by a community mental health center capable of the diagnostic evaluations. An alternative diagnostic facility may be the outpatient service of a state mental health institute or any organization or individual able to furnish the requisite skills and to meet the standards set forth in this chapter by the mental health and disability services commission.

“*Mental health professional*” means an individual who has either of the following qualifications:

1. The individual meets all of the following requirements:

- Holds at least a master’s degree in a mental health field, including, but not limited to, psychology, counseling, guidance, nursing, or social work; or is an advanced registered nurse practitioner, a physician assistant, or a physician and surgeon; or is an osteopathic physician and surgeon.

- Holds a current Iowa license if practicing in a field covered by an Iowa licensure law.

- Has at least two years of postdegree clinical experience, supervised by another mental health professional, in assessing mental health needs and problems and in providing appropriate mental health services.

2. The individual holds a current Iowa license if practicing in a field covered by an Iowa licensure law and is a psychiatrist, an advanced registered nurse practitioner who holds national certification in psychiatric mental health care and is licensed by the board of nursing, a physician assistant practicing under the supervision of a psychiatrist, or an individual who holds a doctorate degree in psychology and is licensed by the board of psychology.

“*Preliminary diagnostic evaluation*” means an assessment of a person’s mental health problems and needs in order to determine the most appropriate service for the person. The evaluation includes, but is not limited to, an assessment of the individual’s needs, abilities, disabilities, and relevant environmental factors. Where possible, there is collaboration with the individual’s family or significant others as appropriate.

[ARC 6224C, IAB 3/9/22, effective 5/1/22]

441—34.2(225C) Function. An alternative diagnostic facility shall:

34.2(1) Perform a preliminary diagnostic evaluation of a person who is being considered for admission to a state mental health institute on a voluntary basis pursuant to Iowa Code chapter 229 in order to:

a. Confirm that admission of the person to a state mental health institute is appropriate to the person’s mental health needs, and that no suitable alternative method of providing the needed services in a less restrictive setting, in or nearer to the person’s home community, is currently available. When results of the evaluation indicate that admission to the mental health institute is appropriate, the evaluator shall inform the institute of the results.

b. Confirm that admission to a state mental health institute is not appropriate to the person’s mental health needs. When results of the evaluation indicate that a treatment program, other than that of a state mental health institute, is more appropriate, and the individual agrees, the evaluator shall make arrangements with the alternative program to accept the referral.

34.2(2) Assist the court and, insofar as possible, provide or designate a physician or mental health professional to perform a prehearing examination of a respondent required under Iowa Code section 229.8(3) “*b.*”

[ARC 6224C, IAB 3/9/22, effective 5/1/22]

441—34.3(225C) Standards. In order to be designated as an alternative diagnostic facility, a facility shall meet the following standards:

34.3(1) The facility shall have clearly defined lines of authority and accountability so that a contractual agreement may be entered into with a county for the provision of preliminary diagnostic evaluations.

34.3(2) The preliminary diagnostic evaluation shall be performed by a mental health professional within a reasonable time frame, not to exceed 48 hours.

34.3(3) The mental health professional shall be familiar with the mental health institute serving the area and with the treatment resources of the community served.

34.3(4) The facility shall have written procedures for timely reporting of results of evaluations to the selected treatment resource.

34.3(5) The facility shall have written policies and procedures to safeguard the consumer's right to treatment, confidentiality, and freedom of choice. The policies and procedures shall be in conformance with federal and state laws and rules.

34.3(6) The facility shall have written procedures for fees for services.

34.3(7) The facility shall comply with procedures for uniform reporting of statistical data as established by the division of mental health and disability services.

34.3(8) The facility shall comply with the standards for the maintenance and operation of public and private facilities offering services to persons with mental illness as adopted by the mental health and disability services commission.

[ARC 6224C, IAB 3/9/22, effective 5/1/22]

These rules are intended to implement Iowa Code sections 225C.4 and 225C.17.

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¹ As Agency 566—Chapter 2

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

b. Reserved.

c. Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."

d. Acupuncture treatments.

e. Reserved.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the 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 be developed by the 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 IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Reserved.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.
- (4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma.

However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- (1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13) “*e.*” On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Reserved.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician’s services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician’s professional service.

a. Auxiliary personnel are nurses, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member’s home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules in 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants’ professional licensure rules in 645—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2) “*n.*” Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs “*b*” through “*f*” shall be effectively presented to a blind, deaf, hard-of-hearing, or otherwise disabled individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16) “*b*” shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(4))

78.1(19) Preprocedure review by the 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 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 IME medical services unit and the department. If not so approved by the 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 the IME medical services unit.

78.1(20) Transplants.

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

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

(4) Liver transplants for persons with extrahepatic biliary 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 IME medical services unit. (Cross references 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 IME medical services unit. (Cross references 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 IME medical services unit. (Cross references 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.

- 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 IME medical services unit. (Cross references 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.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph “a.”

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) Reserved.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

78.1(25) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 5418C**, IAB 2/10/21, effective 4/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) Qualified prescriber. All drugs are covered only if prescribed or ordered by an Iowa Medicaid-enrolled practitioner licensed or registered to prescribe as specified in Iowa Code section 155A.3(38).

78.2(2) Prescription required. As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription or drug order, a prescription or drug order shall be transmitted as specified in Iowa Code sections 124.308, 155A.3 and 155A.27 by the practitioner to the pharmacy, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions or drug orders shall be available for audit by the department.

78.2(3) Qualified source. All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) Prescription drugs. Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

(4) Prior authorization for medication-assisted treatment shall be governed pursuant to subrule 78.28(2).

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Reserved.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes.

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

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 81 mg, chewable
Aspirin tablets 81 mg, 325 mg, and 650 mg oral
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
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 solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)
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
Guaiifenesin 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%
Levonorgestrel 1.5 mg
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride liquid 1 mg/7.5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml

Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 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
 Vitamins, single and multiple with prior authorization
 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.

78.2(6) Quantity prescribed.

a. Quantity prescribed. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe not less than a one-month supply of covered prescription and nonprescription medication. Contraceptives may be prescribed in three-month quantities.

b. Prescription refills.

(1) Prescription refills shall be performed and recorded in a manner consistent with existent state and federal laws, rules and regulations.

(2) Automatic refills.

1. Automatic refills are allowed. Participation in an automatic refill program is voluntary and opt-in only, on a drug-by-drug basis.

2. The program must have:

- Easy-to-locate contact information through telephone, the program's website, or both;
- Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
- Confirmation that the member wants to continue in the automatic refill program at least annually;
- Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the

pharmacy or before the medication is mailed or delivered to the member, without which confirmation the drug(s) must be credited back to the Medicaid program; and

- Records of all consents, which must be in electronic or written format and must be available for review by auditors.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11; ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9882B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(6)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)“b”(1) to (10) except for 78.2(4)“b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)“b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Reserved.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.
Blood bank services.
Cardiology.
Cardiovascular surgery.
Dialysis.
Dietary services.
Gastroenterology.
Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.
Pharmaceutical services.
Physical therapy.
Psychiatry.
Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. *Experience and survival rates.*

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must

specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by 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 the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by 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 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 the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is 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.

78.3(16) Skilled nursing care in “swing beds.”

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be 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) and 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. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

- (1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
- (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”
- (3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
- (4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:
 1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.
 2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.
 3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.
- (5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.
- (6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Reserved.

78.3(18) Preprocedure review by the 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 the IME medical services unit. (Cross reference 78.28(6))

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0844C, IAB 7/24/13, effective 7/1/13; ARC 1054C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) Diagnostic services. Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panoramic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Reserved.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Reserved.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) "a"(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(3) "a"(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(3) "c")

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(3) "b"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3) "b"(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

- (1) Have a physical or mental condition that precludes the use of a removable partial denture, or
- (2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3) “c”)

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) Adjunctive general services. Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) Orthodontic services to members 21 years of age or older. Orthodontic procedures are not covered for members 21 years of age or older.

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

[ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.
- c.* Molded digital orthotic.

- d. Shoe padding when appliances are not practical.
- e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f. Rams horn (hypertrophic) nails.
- g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services. Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through seven years of age.

3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Reserved.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

- (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
- (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
- (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
- (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
- (5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a.* Corrected curve lenses, unless clinically contraindicated.
- b.* Standard plastic, plastic and metal combination, or metal frames.
- c.* Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

- (1) Spectacle lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Safety frames.
- (5) Subnormal visual aids.
- (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(4))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

- a.* Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b.* Glasses for occupational eye safety.
- c.* A second pair of glasses or spare glasses.
- d.* Cosmetic surgery and experimental medical and surgical procedures.
- e.* Sunglasses.
- f.* Progressive bifocal or trifocal lenses.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

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

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. 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 physician, nurse practitioner, clinical nurse specialist, or physician assistant.
 - (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.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

78.9(2) Supervisory visits. Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) Skilled nursing services. Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's, nurse practitioner's, clinical nurse specialist's, or physician assistant's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or

housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.* Rescinded IAB 3/29/17, effective 5/3/17.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.

- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.
- (5) Extended hospitalization and separation from other family members.
- (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
- (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
- (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
- (9) Discharge or release against medical advice before 36 hours of age.
- (10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

- (1) Child or sibling victim of child abuse or neglect.
- (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
- (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
- (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
- (5) Malignancies such as leukemia or carcinoma.
- (6) Severe injuries necessitating treatment or rehabilitation.
- (7) Disruption in family or peer relationships.
- (8) Suspected developmental delay.
- (9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those 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 the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

- 1. Respite care, which is a temporary intermission or period of rest for the caregiver.
- 2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- 3. Services provided to other persons in the member's household.
- 4. Services requiring prior authorization that are provided without regard to the prior authorization process.
- 5. Transportation services.

6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity 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, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) 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. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)"k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)“*n*” for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)“*f*” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser.

Bathtub/shower chair, bench. See 78.10(5)“*g*” and “*j*” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)“*j*” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)“*a*” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)“*c*” for prior authorization requirements.

Insulin infusion pump. See 78.10(5)“*b*” and 78.10(5)“*e*” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)“*i*” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)“a” and 78.10(2)“c.”

Patient lift. See 78.10(5)“h” for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)“f” for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member’s condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed “PRN” or “as necessary” is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;

3. Positioning accessories;
 4. Specialized skin protection seat and back cushions; and
 5. Anti-rollback devices.
- (3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:
1. Lap belt or safety belt;
 2. Battery charger, single mode;
 3. Complete set of tires/wheels and casters, any type;
 4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
 5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
 6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
 7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
 8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
 10. Non-expandable controller or standard proportional joystick (integrated or remote); and
 11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).
- (4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:
1. Shoulder harness/straps or chest straps/vest;
 2. Elevating legrest;
 3. Angle adjustable footplates;
 4. Adjustable height armrests; and
 5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).
- (5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.
- 78.10(3) Prosthetic devices.** Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.
- a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.
 - b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:
 - (1) Artificial eyes.
 - (2) Artificial limbs.
 - (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
 - (4) Hearing aids. See rule 441—78.14(249A).

- (5) Orthotic devices. See 78.10(3)“c” for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.
- (8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
- (9) Tracheotomy tubes.
- (10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

- (1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
 - 1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
 - 2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

- Catheter (indwelling Foley).
- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)“e” for prior authorization requirements.
- Dialysis supplies.
- Disposable catheterization trays or sets (sterile).
- Disposable irrigation trays or sets (sterile).
- Disposable saline enemas (e.g., sodium phosphate type).
- Dressings.
- Elastic antiembolism support stocking.
- Enema.
- Hearing aid batteries.
- Incontinence products (for members three years of age and older).
- Oral nutritional products. See 78.10(5)“m” for prior authorization requirements.
- Ostomy appliances and supplies.
- Respirator supplies.
- Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Rescinded IAB 12/30/20, effective 3/1/21.

e. DME rebate agreements. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged

from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"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 is licensed by the applicable state authority for that profession.

"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.

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;
2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the member's managed care plan for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The member's managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

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

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.
- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1) "b"(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1) "b"(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) "b."

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs "c" to "h" below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified

occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Reserved.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member's home.

1. Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.

2. Under no circumstances will the IME or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1) "b"(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1) "b"(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy.

A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b" (7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b" (8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical,

functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1) "b"(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1) "b"(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

- (1) To whom the services were provided (patient, family member, etc.).
- (2) Prior teaching, training, or counseling provided.
- (3) The medical necessity of the rendered services.
- (4) The identification of specific services and goals.
- (5) The date of the start of the services.
- (6) The frequency of the services.
- (7) Progress in response to the services.
- (8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered

nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Reserved.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Reserved.

b. Education, which shall include as appropriate education about the following:

- (1) High-risk medical conditions.
- (2) High-risk sexual behavior.
- (3) Smoking cessation.
- (4) Alcohol usage education.
- (5) Drug usage education.
- (6) Environmental and occupational hazards.
- c. Nutrition assessment and counseling, which shall include:
 - (1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
 - (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
- d. Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
- e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the 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 the IME medical services unit. (Cross reference 78.28(7))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

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 Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Certified employment specialist*” or “*CES*” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“*Child and Adolescent Level of Care Utilization System*” or “*CALOCUS*” means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 16 to 18.

“Comprehensive service plan” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“Customized employment” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Department” means the Iowa department of human services.

“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” or *“IPS”* means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition-2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.

4. Attention to worker preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments.

5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.

6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.

7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are

similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“*Integrated health home*” means the provision of services to enrolled members as described in subrule 78.53(1).

“*Intensive residential service homes*” or “*intensive residential services*” means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in 441—subrule 25.6(8).

“*Interdisciplinary team*” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“*ISIS*” means the department’s individualized services information system.

“*Level of Care Utilization System*” or “*LOCUS*” means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 19 and older.

“*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.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“*Severe and persistent mental illness*” means the same as defined in rule 441—25.1(331).

“*Supported employment*” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“*Supported self-employment*” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“*Sustained employment*” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. *Age.* The member is at least 16 years of age or older.

b. *LOCUS/CALOCUS actual disposition.* The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

c. *Risk factors.* The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., crisis response services, subacute mental health services, emergency services,

alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member is currently receiving habilitation or integrated health home services; or

(3) The member has a history of severe and persistent mental illness resulting in at least one episode of continuous, professional supportive care other than hospitalization (e.g., counseling, therapy, assertive community treatment, or medication management); or

(4) The member has a history of severe and persistent mental illness resulting in involvement in the criminal justice system (e.g., prior incarceration, parole, probation, criminal charges, jail diversion program or mental health court); or

(5) Traditional mental health services available in the member's community have not been able to meet the member's needs.

d. Need for assistance. The member has a need for assistance or is likely to need assistance related to functional impairment arising out of a mental health diagnosis typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least 12 months:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history, and the member is currently receiving employment services or the member has a need for employment services to obtain or maintain employment.

(2) The member requires financial assistance to reside independently in the community or may be homeless or at risk of homelessness if unable to procure this assistance without help.

(3) The member shows significant inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits social behavior that puts the member's safety or others' safety at risk, which results in the need for service intervention which may include crisis management or protective oversight.

e. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

f. Needs assessment. The LOCUS or CALOCUS tool has been completed in the LOCUS online system, and using the algorithm developed by Deerfield Solutions to derive the actual disposition score based on the comprehensive assessment and social history (CASH) completed by the integrated health home (IHH) or community-based case manager (CBCM) during a face-to-face interview with the member and the member's representative as applicable, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The LOCUS/CALOCUS information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the LOCUS or CALOCUS, before services begin and annually thereafter, and more frequently if significant observable changes occur in the member's situation, condition or circumstances.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4) and 441—paragraph 90.4(1) "b" before services begin and annually thereafter, and when there is a significant observable change in the member's situation, condition, or circumstances.

g. Plan for service. The department or the member's managed care organization 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 by the IME or the member's managed care organization 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) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1) "b." A service plan may change when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member's LOCUS/CALOCUS actual disposition, the LOCUS/CALOCUS composite score, and each individual domain score for each of the six LOCUS/CALOCUS domains.

(3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

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 IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(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 IME medical services unit in 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 or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

- (1) Identify observable or measurable individual goals.
- (2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- (3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.
- (4) List all Medicaid and non-Medicaid services received by the member and identify:
 1. The name of the provider responsible for delivering the service;
 2. The funding source for the service; and
 3. The number of units of service to be received by the member.
- (5) Identify for a member receiving home-based habilitation:
 1. The member's living environment at the time of enrollment;
 2. The number of hours per day of on-site staff supervision needed by the member; and
 3. The number of other members who will live with the member in the living unit.
- (6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

- (1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
- (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
- (3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. 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)“g.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a.* The services shall be based on the member's needs as identified in the member's comprehensive service plan.
- b.* The services shall be delivered in the least restrictive environment appropriate to the needs of the member.
- c.* The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- d.* Service components that are the same or similar shall not be provided simultaneously.
- e.* Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.
- f.* Reimbursement is not available for room and board.
- g.* Services shall be billed in whole units.
- h.* Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions.

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities to address daily living needs;
- (3) Assistance with symptom management and participation in mental health treatment;
- (4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;
- (5) Assistance with accessing and participating in substance use disorder treatment and services;
- (6) Assistance with medication administration and medication management;
- (7) Assistance with understanding communication whether verbal or written;
- (8) Community inclusion and active participation in the community;
- (9) Transportation;
- (10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;
- (11) Social and leisure skill development;
- (12) Personal care; and
- (13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member’s home and community.

(1) A member may live in the member’s own home, within the home of the member’s family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.25(5).

(2) A member living with the member’s family or legal representative is not subject to the criteria in 441—paragraphs 77.25(8) “c” and “d.”

(3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member’s most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and
2. The member meets the criteria in 441—subparagraph 25.6(8) “c”(3).

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 17.5 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside the family home may only receive home-based habilitation services in residential settings with 16 or fewer beds licensed by the department of inspections and appeals.

(3) The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

(4) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

e. Additional criteria for receiving home-based habilitation services for transition-age youth 17.5 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Individuals 17.5 to 18 years of age shall receive 24-hour site supervision and support.
- Individuals under the age of 18 may not reside in settings with individuals over the age of 21.
- The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
- For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member's parent or guardian has consented to home-based habilitation services.

4. The member is able to pay room and board costs (funding sources may include, but are not limited to, supplemental security income, child support, adoptions subsidy, or private funds).

5. A licensed setting, such as those approved to provide residential-based supported community living, is not available.

f. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member’s individual goals as identified in the member’s comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

- (1) Identifying the member’s interests, preferences, skills, strengths and contributions,
- (2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
- (3) Planning and coordination of the member’s individualized daily and weekly day habilitation schedule,
- (4) Developing skills and competencies necessary to pursue competitive integrated employment,
- (5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
- (6) Participating in community activities related to cultural, civic, and religious interests,
- (7) Participating in adult learning opportunities,
- (8) Participating in volunteer opportunities,
- (9) Training and education in self-advocacy and self-determination to support the member’s ability to make informed choices about where to live, work, and recreate,
- (10) Assistance with behavior management and self-regulation,
- (11) Use of transportation and other community resources,
- (12) Assistance with developing and maintaining natural relationships in the community,
- (13) Assistance with identifying and using natural supports,
- (14) Assistance with accessing financial literacy and benefits education,
- (15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

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

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member’s residence. Family training may be provided in the member’s home.

e. Duration. Day habilitation services shall be furnished as specified in the member’s comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

g. Concurrent services. A member’s comprehensive service plan may include two or more types of nonresidential habilitation services (e.g., day habilitation, individual supported employment,

long-term job coaching, small-group supported employment, and prevocational services). However, more than one service may not be billed during the same period of time (e.g., the same hour).

h. Transportation. When transportation is provided to the day habilitation service location from the member's home and from the day habilitation service location to the member's home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving day habilitation services.

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,

2. Business tours,

3. Informational interviews,

4. Job shadows,

5. Benefits education and financial literacy,

6. Assistive technology assessment, and

7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9) "a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business

days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)“a”(1). This time limit can be extended as stated in paragraphs 78.27(9)“e”(1)“1” through “6.” If the criteria in paragraphs 78.27(9)“e”(1)“1” through “6” do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) Supported employment services.

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)“a”(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.
- b. *Long-term job coaching.* Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member’s personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider’s organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).

12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.

13. Transportation of the member during service hours.
 14. Career exploration services leading to increased hours or career advancement.
- (5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment.

In addition to the activities listed under subparagraph 78.27(10)“b”(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member’s comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member’s residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

d. Individual placement and support (IPS).

(1) IPS shall include the following activities, which shall be described and documented in the member’s employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.

2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.

3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.

4. Rapid job search and systematic job development. CESs help members seek jobs directly, and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.

5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.

6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.
2. Outcome #2: First day of successful job placement.
3. Outcome #3: 45 days successful job retention.
4. Outcome #4: 90 days successful job retention.

e. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above

minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

f. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,167.89 per month.

(3) Individual supported employment is limited to 60 hourly units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

g. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department 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 determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 120 consecutive days in any one stay.

When a member has been an inpatient in a medical institution for 120 consecutive days, the department

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) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. 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 or of the LOCUS/CALOCUS actual disposition score 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.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5809C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 5889C, IAB 9/8/21, effective 11/1/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Rescinded IAB 12/30/20, effective 3/1/21.

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“*l.*”

d. Reserved.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“*f.*”

f. Preprocedure review by the 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 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 criteria established by the department and the IME medical services unit. If not so approved by the 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 the IME medical services unit.

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“*a.*”

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)“*c.*”)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“*m.*”

- j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“c.”
- k.* DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5)“e.”
- l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“n.”
- m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“g.”
- n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“h.”
- o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“i.”
- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“j.”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

78.28(2) Notwithstanding the provisions of 78.28(1)“a,” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a.* Buprenorphine,
- b.* Buprenorphine and naloxone combination,
- c.* Methadone,
- d.* Naltrexone, and
- e.* Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services which require prior approval are as follows:

- a.* The following periodontal services:
 - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“b.”
 - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“d.”
 - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“e.”
 - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“f.”
 - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“g.”
- b.* The following prosthetic services:
 - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“b.”
 - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“d.”
 - (3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”
 - (4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”
 - (5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”
 - (6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”
 - (7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”
 - (8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”

- c.* The following orthodontic services:
- (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“*a.*”
 - (2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“*b.*”
 - (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“*c.*”
- d.* The following restorative services:
- (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“*d*”(3).
 - (2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“*d*”(4).
- e.* Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“*d.*”
- f.* Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“*g.*”

78.28(4) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

- a.* A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.
- b.* Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.
- c.* Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.
- d.* Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.
- e.* Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(5) Hearing aids that must be submitted for prior approval are:

- a.* Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7)“*d*”(1))
- b.* A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7)“*d*”(2)):
- (1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.
 - (2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise

or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the 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 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. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care 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 based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those 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 the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services

shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity 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, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) 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. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) "b")

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) "b," the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;

- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12)“*a,*” prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department of human services.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

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 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.* Emergency service.
- b.* Outpatient surgery.
- c.* Laboratory, X-ray and other diagnostic services.
- d.* General or family medicine.
- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs "d" and "f" and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Vaccines. In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) Application for certification. Hospital outpatient programs listed in subrule 78.31(1), paragraphs “g” to “m,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall

apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected

as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 6222C, IAB 3/9/22, effective 5/1/22]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

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

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

- a. Components of the service include, but are not limited to:
 - (1) Observation and reporting of physical or emotional needs.
 - (2) Helping a client with bath, shampoo, or oral hygiene.
 - (3) Helping a client with toileting.
 - (4) Helping a client in and out of bed and with ambulation.
 - (5) Helping a client reestablish activities of daily living.
 - (6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.
 - (7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

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

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

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

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) “f” and the skilled activities listed in paragraph 78.34(7) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above

the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle

modification provider following completion of the approved modifications. Payment of up to \$6,592.66 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) Consumer choices option. The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Prevocational services.
4. Basic individual respite care.
5. Specialized medical equipment.
6. Supported community living.
7. Supported employment.
8. Transportation.

(6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)“b”(7) or the utilization adjustment factor in subparagraph 78.34(13)“b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)"d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.

14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.

24. Residential services provided to three or more members living in the same residential setting.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13) "b"(11).

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13) "d." The savings plan shall meet the requirements in paragraph 78.34(13) "f."

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and

3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

(1) Recruit and hire employees.

(2) Verify employee qualifications.

(3) Specify additional employee qualifications.

(4) Determine employee duties.

(5) Determine employee wages and benefits.

(6) Schedule employees.

(7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h." Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member's service plan.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.

(4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.
- (18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member's employee(s) are responsible for the following:

- (1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.
- (2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.
- (3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.
- (4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet (Form 470-4429) or use Form 470-4429. All other employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).
- (5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)"m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

- a.* Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b.* All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c.* All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
 - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.

- (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
 - e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their

life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When

an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member’s service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member’s age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member’s service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a.* Observation and reporting of physical or emotional needs.
- b.* Helping a client with bath, shampoo, or oral hygiene.
- c.* Helping a client with toileting.
- d.* Helping a client in and out of bed and with ambulation.

- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

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

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) "a," as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

- a. Chore services are limited to the following services:
 - (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
 - (2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15) "*f*" and the skilled activities listed in paragraph 78.37(15) "*g*." Covered service activities must be essential to the health, safety, and welfare

of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.37(16) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) *Assisted living service.* The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

- (1) The member was present in the facility during that day's bed census.
- (2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) *General service standards.* All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
- (2) The need for the restriction.
- (3) The less intrusive methods of meeting the need that have been tried but did not work.
- (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
- (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
- (6) The informed consent of the member.

- (7) An assurance that the interventions and supports will cause no harm to the member.
- (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals

exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) “f” and the skilled activities listed in paragraph 78.38(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

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

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human

body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

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

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

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

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

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

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

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.
- i. Payment for respite services shall not exceed \$7,595 per the member's waiver year.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of the system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 - 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 - 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)“f” and the skilled activities listed in paragraph 78.41(8)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.

- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical

care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) Residential-based supported community living services. Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation.* Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) *Consumer choices option.* The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3481C**, IAB 12/6/17, effective 12/1/17; **ARC 3790C**, IAB 5/9/18, effective 6/13/18; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 5305C**, IAB 12/2/20, effective 2/1/21; **ARC 5307C**, IAB 12/2/20, effective 2/1/21; **ARC 5597C**, IAB 5/5/21, effective 7/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21; **ARC 5896C**, IAB 9/8/21, effective 8/17/21; **ARC 6122C**, IAB 12/29/21, effective 3/1/22]

441—78.42(249A) Pharmacists providing covered vaccines. When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) *Vaccines administered to children.* Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) *Vaccines administered to adults.* Payment will be made to an enrolled provider for an administration fee and vaccine cost.

78.42(3) Verification and reporting. Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient's primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 5175C, IAB 9/9/20, effective 6/1/21]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

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

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and

prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

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

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

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

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs

shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

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

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

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

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

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf or hard of hearing.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.
- f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,592.66 per year may be made to certified providers upon satisfactory completion of the service.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
 - (1) The necessary components of a system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
 - (2) The service shall be identified in the member's service plan.
 - (3) A unit is a one-time installation fee or one month of service.
 - (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.
- b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law

enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

- (1) Provide for health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,592.66 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing

programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.43(14) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

- a. The member is at least 17 years old.
- b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:
 - (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
 - (2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and
 - (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.
- c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.
- d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:
 - (1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or
 - (2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

- (1) Is medically stable;
- (2) Does not require a level of care that includes more intensive medical monitoring;
- (3) Presents a low risk to self, others, or property, with treatment and support; and
- (4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

- (1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and
- (2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.
2. Assisting the member in gaining access to necessary medical, social, educational, and other services.
3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
2. Make referrals to services and related activities to assist the member with the assessed needs.
3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,592.66 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,592.66 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 5597C**, IAB 5/5/21, effective 7/1/21; **ARC 5808C**, IAB 7/28/21, effective 9/1/21; **ARC 5896C**, IAB 9/8/21, effective 8/17/21; **ARC 6122C**, IAB 12/29/21, effective 3/1/22]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;

2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;

3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. *New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. *Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for

any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a. Reserved.
- b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Reserved.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a. Reserved.
- b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service

638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

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

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

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

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

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

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

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

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

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

(6) Developing medication management skills.

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

(8) Developing positive socialization and citizenship skills.

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

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

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

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

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

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

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

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

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

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 3874C**, IAB 7/4/18, effective 8/8/18; **ARC 5305C**, IAB 12/2/20, effective 2/1/21]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

- (1) Medication adherence;
- (2) Chronic disease management;
- (3) Appointments, referral scheduling, and reminders; and
- (4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

- (1) Supporting health management;
- (2) Improving disease control; and
- (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

- (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
- (2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

- (1) Communicating with and advocating for the member or family for the assessment of care decisions;
- (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
- (3) Increasing health literacy and self-management skills; and
- (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) Members eligible for health home services.

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or
- (4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

- (1) A mental health disorder.
- (2) A substance use disorder.
- (3) Asthma.
- (4) Diabetes.
- (5) Heart disease.
- (6) Being overweight, as evidenced by:
 1. Having a body mass index (BMI) over 25 for an adult, or
 2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most

current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term “functional impairment” means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person’s role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person’s environment.

78.53(3) Selection of health home services provider. As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member’s health home, as reported by the provider. A member must select a provider located in the member’s county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) Definitions.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Brain injury*” means a diagnosis in accordance with rule 441—83.81(249A).

“*Health care*” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

“*Intermittent community-based neurobehavioral rehabilitation services*” are provided to a Medicaid member on an as-needed basis to support the member and the member’s family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member’s own home and community.

“*Member*” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“*Neurobehavioral rehabilitation*” refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the

member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.56(2) Member eligibility. To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member's managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury and must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. Emergency admission. In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) Covered services.

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

- (1) Prescriptive programming to maintain and advance progress made in rehabilitation;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Assistance in obtaining preventative, appropriate and timely medical and dental care;
- (4) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;
- (6) Behavioral and cognitive programming and supports;
- (7) Medication management and consultation with pharmacy;
- (8) Health and wellness management including dietary and nutritional programming;
- (9) Progressive physical strengthening, fitness and retraining;
- (10) Assistance with obtaining and use of assistive technology;
- (11) Sobriety support development;
- (12) Assistance with the self-identification of antecedent triggers;
- (13) Assistance with preparation for transition to less intensive services including accessing the community;
- (14) Flexibility in programming to meet individual needs;
- (15) Assistance with re-learning coping and compensatory strategies;
- (16) Support and assistance in seeking substance abuse and co-occurring disorders services;
- (17) Support and assistance with obtaining legal consultation and services;
- (18) Assistance with community accessibility and safety;
- (19) Assistance with re-learning household maintenance;
- (20) Assistance with recreational and leisure skill development;
- (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (22) Opportunities to learn about brain injury and individual needs following brain injury;
- (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (24) Assistance with pursuit of education and employment goals;
- (25) Protective oversight in the residential setting and community;
- (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
- (27) Transitional support and training;
- (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
- (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;

- (8) Assistance with re-learning coping and compensatory strategies;
- (9) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
- (12) Transitional support and training;
- (13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

- (1) The IME medical services unit will approve the provider's treatment plan if:
 1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
 2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;
 3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
 4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
 5. The treatment plan does not exceed 180 days in duration.
- (2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

- g.* Quality review. The IME medical services unit may perform the quality review to evaluate:
- (1) The time elapsed from referral to rehabilitation treatment plan development;
 - (2) The continuity of treatment;
 - (3) The length of stay per member;
 - (4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;
 - (5) Gaps in service;
 - (6) The results achieved;
 - (7) Member and stakeholder satisfaction;
 - (8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a.* Consistent with the diagnosis and treatment of the member's condition;
- b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c.* The least costly type of service that can reasonably meet the medical needs of the member; and
- d.* In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:
 - (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
 - (2) The professional literature regarding best practices in the field.

78.56(5) Documentation standards. Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

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(5). 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(5). 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, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). 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) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "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(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

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

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 plan of care 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 acute recurrence of illness or symptoms.
 9. 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(7)** 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.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

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

“*Copayment*” means a fixed amount a member pays for a covered health care service.

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

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the

individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

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

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member's health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

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

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

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

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
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[Filed ARC 6222C (Notice ARC 6081C, IAB 12/15/21), IAB 3/9/22, effective 5/1/22]

- 1 Two ARCs
- 2 Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
- 3 Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
- 4 Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.
- 5 Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- 6 Two ARCs
- 7 Two ARCs
- 8 At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- 9 Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- 10 Two or more ARCs
- 11 July 1, 2009, effective date of amendments to 78.27(2)"d" delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- 12 May 11, 2011, effective date of 78.34(5)"d," 78.38(5)"h," 78.41(2)"g," 78.43(3)"d," and 78.52(5)"a" delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.
- 13 July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- 14 March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.

CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]

[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*Advance directive*” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Clock hour*” means 60 minutes.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

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

“*Direct care component*” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. “Direct care component” also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“*Discharged resident*” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“*Facility*” means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 as amended to December 4, 2017, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“*Facility-based nurse aide training program*” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“*Facility cost report period case-mix index*” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“*Facilitywide average case-mix index*” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“*Informed consent*” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

“*Laboratory experience*” means practicing care-giving skills prior to contact in the clinical setting.

“*Level I review*” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

“*Level II review*” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“*Major renovations*” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$1.5 million. The \$1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$1.5 million threshold.

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

“*Medicaid average case-mix index*” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“*Minimum data set*” or “*MDS*” refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.6(16) “f.” MDS is described in subrule 81.13(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“Nurse aide training and competency evaluation programs (NATCEP)” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“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.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Poor performing facility (PPF)” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

“Primary instructor” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“Program coordinator” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“Rate determination letter” means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

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

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

“Skills performance record” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“Special population nursing facility” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with medical complexity.

“Surgical or other invasive procedure” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“Terminated from the Medicare or Medicaid program” means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 3717C, IAB 3/28/18, effective 7/1/18; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—81.2 Reserved.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.3(1) “*b*,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) Reserved.

81.3(3) *Preadmission review.* The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person’s attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person’s physical condition, and the person is not a danger to self or others. If the person’s nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person’s illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson’s disease, Huntington’s chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person’s caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14) "b," using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14) "c," using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.

c. The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3) "a" has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident's knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) "a" and 249A.4.
 [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.4(249A) Arrangements with residents.**81.4(1)** Reserved.

81.4(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 payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See subrule 81.13(5)“c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)“a,” and 249A.4.

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

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

81.5(2) Case activity report. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician's orders for care.
- f. The resident's personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.5(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.6(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of "direct patient care costs" and "support care costs." Costs associated with food and dietary wages shall be included in the "support care costs" subcategory.

81.6(3) Submission of reports. All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider's reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the

facility's established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3) "e."

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

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

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

f. When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

81.6(4) Payment at new rate.

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) Accrual basis. Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) Census of Medicaid members. Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.6(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.6(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent,

child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

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

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing

facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11) “h”(4) to 81.6(11) “h”(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator’s salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association Useful Life Guide.

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider’s qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.6(11)"*l*," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11)"*j*" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.6(11)"*l*," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.6(11)"*j*" plus the landlord's other expenses; or

2. Actual rent payments.

n. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

o. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) “*a.*”

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) “*d.*” The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider’s reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.6(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days’ prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the

facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.6(14) Payment to new facility. The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

81.6(15) Payment to new owner. An existing facility with a new owner shall continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility’s fiscal year will end.

81.6(16) Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate. This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph “a”) determines the per diem direct care and non-direct care component costs. The second step (paragraph “b”) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph “c”) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph “d”) calculates the potential excess

payment allowance. The fifth step (paragraph “e”) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph “h,” that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph “h,” in step six (paragraph “f”). The seventh step (paragraph “g”) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are

recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess

payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph "d," not to exceed the rate component limits determined by the methodology in paragraph "f."

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph "d."

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph "d" and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph "h."

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs "d" and "e," in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph "h."

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51

points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification

Standard	Measurement Period	Value	Source
Subcategory: Resident Satisfaction			
<p>Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
<p>Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.</p>	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
Subcategory: Staffing			
<p>Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p>Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
<p>Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results

Standard	Measurement Period	Value	Source
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	IME medical services unit report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard

Standard	Measurement Period	Value	Source
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from a report submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16)"g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “*f.*”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “*f.*” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “*g.*” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider

Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.
2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses

for non-state-owned facilities shall be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph “f.” The facility’s quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility’s medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

81.6(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility’s fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility’s fiscal year and the midpoint of the facility’s fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

- a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.
- b. The starting and average hourly wage for each class of employees for the period of the report.
- c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) Inflation factor. The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in

the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

81.6(19) Case-mix index calculation.

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

81.6(20) Medicare crossover claims for nursing facility services.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"Medicaid reimbursement" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.6(21) Nursing facility quality assurance payments.

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$15 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. End date. If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4428C, IAB 5/8/19, effective 7/1/19; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 6226C, IAB 3/9/22, effective 5/1/22]

441—81.7(249A) Continued review.

81.7(1) Level of care. The IME medical services unit shall review Medicaid members' need 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.

81.7(2) PASRR. As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility

immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

- a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);
- b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and
- c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.3(3)“b.”

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.
 [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.8 Reserved.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:

- a. All records required by the department of public health and the department of inspections and appeals.
- b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.
- c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.
- d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.
- e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.
- f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.
 - (1) Census information shall be provided for all residents of the facility.
 - (2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.
 - (3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.
- g. Resident accounts.
- h. In-service education program records.
- i. Inspection reports pertaining to conformity with federal, state and local laws.
- j. Residents' personal records.
- k. Residents' medical records.
- l. Disaster preparedness reports.

81.9(2) Retention. Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership. This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)“a.”

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Except for Medicaid accountability measures payment established in paragraph 81.6(16)“g,” facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule

441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

81.10(2) *Authorization of payment.* The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Reserved.

81.10(4) *Periods authorized for payment.*

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. Ventilator patients.

(1) Definition. For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) Reimbursement. In-state nursing facilities shall receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.6(16) "j"(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

- (1) The wrong surgical or other invasive procedure is performed on a resident; or
- (2) A surgical or other invasive procedure is performed on the wrong body part; or

(3) A surgical or other invasive procedure is performed on the wrong resident.

81.10(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2)“*d*,” medical supplies except for those listed in 441—paragraph 78.10(4)“*b*,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“*a*,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“*a*”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident's family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

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

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;
- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

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

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

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

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.
- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4) "j" and shall not discharge a resident due to nonpayment for such days.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 0714C, IAB 5/1/13, effective 7/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4900C, IAB 2/12/20, effective 3/18/20]

441—81.11(249A) Billing procedures.

81.11(1) Claims. Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through Iowa Medicaid's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

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

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

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 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."

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

81.13(2) Medicaid provider agreements. The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

a. to d. Reserved.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

81.13(3) Distinct part requirement. All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.13(4) Civil rights. The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities,

room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. Notice of rights and services.

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

c. Protection of resident funds.

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. Free choice. The resident has the right to:

- (1) Choose a personal attending physician.
- (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.
- (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) The facility must respect the resident's right to personal privacy, including the right to privacy in the resident's oral (that is, spoken or sign language), written, and electronic communications.

(3) Except as provided in subparagraph (4) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(4) The resident's right to refuse release of personal and clinical records does not apply to the following:

1. The release of personal and clinical records to a health care institution to which the resident is transferred; or
2. A record release that is required by law.

f. Grievances. A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. Examination of survey results. A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. Work. The resident has the right to:

- (1) Refuse to perform services for the facility.
- (2) Perform services for the facility if the resident chooses, when:
 1. The facility has documented the need or desire for work in the plan of care.
 2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.
 3. Compensation for paid services is at or above prevailing rates.
 4. The resident agrees to the work arrangement described in the plan of care.

i. Mail. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident, whether delivered by a postal service or by other means, including the right to:

- (1) Privacy of such communications consistent with this section; and
- (2) Access to stationary, postage, and writing implements at the resident's own expense.

j. Access and visitation rights.

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.
2. Any representative of the state.
3. The resident's individual physician.
4. The state long-term care ombudsman.
5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.
6. The agency responsible for the protection and advocacy system for mentally ill individuals.
7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.

8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

k. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

q. Electronic communication. The resident has the right to have reasonable access to and privacy in the resident's use of electronic communications, including, but not limited to, email and video communications, and for Internet research:

- (1) If accessible to the facility;
- (2) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident; and
- (3) To the extent that such use may comply with state and federal law.

81.13(6) Admission, transfer and discharge rights.

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
3. The safety of persons in the facility is endangered.
4. The health of persons in the facility would otherwise be endangered.
5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.
2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(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. Record the reasons in the resident's clinical record.
3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.
2. The health of persons in the facility would be endangered.
3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.
4. An immediate transfer or discharge is required by the resident's urgent medical needs.
5. A resident has not resided in the facility for 30 days.
- (6) Contents of the notice. The written notice shall including the following:

1. The reason for transfer or discharge.
2. The effective date of transfer or discharge.
3. The location to which the resident is transferred or discharged.
4. A statement that the resident has the right to appeal the action to the department.
5. The name, address, and telephone number of the state long-term care ombudsman.
6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.
7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)"a"(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)"a," and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money,

donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident’s admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) Resident behavior and facility practices.

a. *Restraints.* The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms.

b. *Abuse.* The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. *Staff treatment of residents.* The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

*(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator’s designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) Quality of life. A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.

a. *Dignity.* The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of the resident’s individuality.

b. *Self-determination and participation.* The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident’s interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. *Participation in resident and family groups.*

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

a. *Admission orders.* At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

b. *Comprehensive assessments.*

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.
2. Customary routine.
3. Cognitive patterns.
4. Communication.
5. Vision.
6. Mood and behavior patterns.
7. Psychosocial well-being.
8. Physical functioning and structural problems.
9. Continence.
10. Disease diagnoses and health conditions.
11. Dental and nutritional status.
12. Skin condition.
13. Activity pursuit.
14. Medications.
15. Special treatments and procedures.
16. Discharge potential.
17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
18. Documentation of participation in assessment.
19. Additional specification relating to resident status as required in Section S of the MDS.

(3) Frequency. Assessments shall be conducted:

1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.

3. In no case less often than once every 12 months.

(4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.

(5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.

(6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(7) Automated data processing requirement.

1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.

- Admission assessment.
- Annual assessment updates.
- Significant change in status assessments.
- Quarterly review assessments.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, if there is no admission assessment.

2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(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.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

f. Reserved.

g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision impairment or the deaf or hard of hearing or the office of a professional specializing in the provision of vision or hearing assistive devices.

c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

d. Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

g. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

h. Accidents. The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

i. Nutrition. Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

j. Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

(1) Injections.

(2) Parenteral and enteral fluids.

(3) Colostomy, ureterostomy or ileostomy care.

(4) Tracheostomy care.

(5) Tracheal suctioning.

(6) Respiratory care.

(7) Foot care.

(8) Prostheses.

l. Unnecessary drugs.

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or

3. Without adequate monitoring; or
4. Without adequate indications for its use; or
5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:

- (1) It is free of significant medication error rates of 5 percent or greater.

- (2) Residents are free of any significant medication errors.

81.13(11) Nursing services. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.

- (1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph "c," licensed nurses.

2. Other nursing personnel.

- (2) Except when waived under paragraph "c," the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.

- (1) Except when waived under paragraph "c," the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

- (2) Except when waived under paragraph "c," the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

- (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph "b," or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph "a," if the following conditions are met:

- (1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

- (2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

- (3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

- (4) A waiver granted under the conditions listed in paragraph "c" is subject to annual department of inspections and appeals review.

- (5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

- (6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older

Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) Dietary services. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) Physician services. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph “e,” all required physician visits shall be made by the physician personally.

d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident’s comprehensive plan of care, the facility shall:

- (1) Provide the required services; or
- (2) Obtain the required services from an outside provider of specialized rehabilitative services.

b. Specialized services for mental illness. “Specialized services for mental illness” means services provided in response to an exacerbation of a resident’s mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) May be provided only by a specialized licensed or certified practitioner;

(5) Are expected to result in specific, identified improvements in the resident’s psychiatric status to the level before the exacerbation of the resident’s mental illness; and

(6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident’s diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. “Specialized services for intellectual disability” means services that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) Must be supervised by a qualified intellectual disability professional; and

(5) May include:

1. A functional assessment of maladaptive behaviors.
2. Development and implementation of a behavioral support plan.
3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.13(15) Dental services. The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

- (1) Routine dental services to the extent covered under the state plan.
- (2) Emergency dental services.

b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office.

c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) Pharmacy services. The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

a. *Procedures.* A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

b. *Service consultation.* The facility shall employ or obtain the services of a licensed pharmacist who:

- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
- (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

c. *Drug regimen review.*

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

d. *Labeling of drugs and biologicals.* Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

e. *Storage of drugs and biologicals.*

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

f. *Consultant pharmacists.* When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly

drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) Infection control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. Infection control program. The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

b. Preventing spread of infection.

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. Linens. Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) Physical environment. The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. Life safety from fire. Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. Emergency power.

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. Resident rooms. Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

- (1) Bedrooms shall:
 1. Accommodate no more than four residents.
 2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.
 3. Have direct access to an exit corridor.
 4. Be designed or equipped to ensure full visual privacy for each resident.
 5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.
7. Have a floor at or above grade level.
- (2) The facility shall provide each resident with:
 1. A separate bed of proper size and height for the convenience of the resident.
 2. A clean, comfortable mattress.
 3. Bedding appropriate to the weather and climate.
 4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

f. Resident call system. The nurse's station shall be equipped to receive resident calls through a communication system from:

- (1) Resident rooms.
- (2) Toilet and bathing facilities.

g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

- (1) Be well lighted.
- (2) Be well ventilated, with nonsmoking areas identified.
- (3) Be adequately furnished.
- (4) Have sufficient space to accommodate all activities.

h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

- (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.
- (2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.
- (3) Equip corridors with firmly secured handrails on each side.
- (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Licensure. A facility shall be licensed under applicable state and federal law.

b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS

regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.
2. Responsible for management of the facility.

e. Required training of nurse aides.

(1) Definitions.

“*Licensed health professional*” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“*Nurse aide*” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;
2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or
3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or
2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility shall:

1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

l. Clinical records.

(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

(2) Clinical records shall be retained for:

1. The period of time required by state law.

2. Five years from the date of discharge when there is no requirement in state law.

3. For a minor, three years after a resident reaches legal age under state law.

(3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.

(4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

1. Transfer to another health care institution.

2. Law.

3. Third-party payment contract.

4. The resident.

(5) The clinical record shall contain:

1. Sufficient information to identify the resident.

2. A record of the resident's assessments.

3. The plan of care and services provided.

4. The results of any preadmission screening conducted by the state.

5. Progress notes.

m. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

n. Transfer agreement.

(1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:

1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.

2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.

(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

o. Quality assessment and assurance.

(1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.

(2) The quality assessment and assurance committee:

1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.

2. Develops and implements appropriate plans of action to correct identified quality deficiencies.

(3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.

(4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

p. Disclosure of ownership.

(1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.

(2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:

1. Persons with an ownership or control interest.

2. The officers, directors, agents, or managing employees.

3. The corporation, association, or other company responsible for the management of the facility.

4. The facility's administrator or director of nursing.

(3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—81.14(249A) Audits.

81.14(1) *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

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

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals, 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. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals 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. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph "d," the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a" and 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.15 Reserved.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) Deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections and appeals if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours' duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.16(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) “e” and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2) “f,” the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2) “b”(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

f. An exception to subparagraph 81.16(2) “*b*”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes’ travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in these rules.

a. For a nurse aide training and competency evaluation program to be approved, such program shall, at a minimum:

(1) Consist of no less than 75 clock hours of training, and

(2) Include at least the subjects specified in 81.16(3) “*b*,” and

(3) Include at least 30 hours of didactic theory instruction, which may be provided in a classroom setting or through online course curricula, and

(4) Include at least 15 hours of laboratory experience provided in a face-to-face environment that complements the didactic theory curricula, and

(5) Include 30 hours of supervised clinical training in a face-to-face environment and supervised by a department of inspections and appeals-approved instructor in a manner not inconsistent with the licensing requirements of the Iowa board of nursing, and

(6) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the department of inspections and appeals-approved instructor, and

(7) Meet the following requirements for department of inspections and appeals-approved instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed by registered nurses under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of department of inspections and appeals-approved instructors to students shall not exceed one registered nurse, or licensed practical nurse functioning as an assistant to a registered nurse, who is in the proximate area in the clinical setting, for every ten students in the clinical setting, and

(8) Contain information regarding competency evaluation through written or oral examination and skills demonstration.

b. The curriculum of the nurse aide training program shall include:

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

1. Communication and interpersonal skills.
2. Infection control.
3. Safety and emergency procedures including the Heimlich maneuver.
4. Promoting residents' independence.
5. Respecting residents' rights.

(2) Basic nursing skills:

1. Taking and recording vital signs.
2. Measuring and recording height and weight.
3. Caring for the residents' environment.
4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.
5. Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to:

1. Bathing.
2. Grooming, including mouth care.
3. Dressing.
4. Toileting.
5. Assisting with eating and hydration.
6. Proper feeding techniques.
7. Skin care.
8. Transfers, positioning, and turning.

(4) Mental health and social service needs:

1. Modifying aide's behavior in response to residents' behavior.
2. Awareness of developmental tasks associated with the aging process.
3. How to respond to resident behavior.
4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.
5. Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).

2. Communicating with cognitively impaired residents.
3. Understanding the behavior of cognitively impaired residents.
4. Appropriate responses to the behavior of cognitively impaired residents.
5. Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

1. Training the resident in self-care according to the resident's ability.
2. Use of assistive devices in transferring, ambulation, eating and dressing.
3. Maintenance of range of motion.
4. Proper turning and positioning in bed and chair.
5. Bowel and bladder training.
6. Care and use of prosthetic and orthotic devices.

- (7) Residents' rights:
1. Providing privacy and maintenance of confidentiality.
 2. Promoting the residents' rights to make personal choices to accommodate their needs.
 3. Giving assistance in resolving grievances and disputes.
 4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
 5. Maintaining care and security of residents' personal possessions.
 6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
 7. Avoiding the need for restraints in accordance with current professional standards.
- c. Prohibition of charges.

(1) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may not be charged for any portion of the program including any fees for textbooks, course materials, or nurse aide competency evaluations.

(2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

1. Add all costs incurred by the nurse aide for the course, books, and competency evaluations.
2. Divide the total arrived at in paragraph "1" above by 12 to prorate the costs over a one-year period and establish a monthly rate.
3. The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:

- (1) Notify the department of inspections and appeals:
 1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
 2. When a facility or other training entity will no longer be offering nurse aide training courses.
 3. Whenever the person coordinating the training program is hired or terminates employment.
- (2) Keep a list of faculty members and their qualifications available for department review.
- (3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
- (4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.
- (5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) Nurse aide competency evaluation. A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.

a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.

b. Content of the competency evaluation program.

- (1) Written or oral examinations. The competency evaluation shall:
 1. Allow an aide to choose between a written and oral examination.
 2. Address each of the course requirements listed in 81.16(3) "b."

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5) "c."

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry

entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) “c”(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide’s social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals. Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3718C, IAB 3/28/18, effective 5/2/18]

441—81.17 Reserved.

441—81.18(249A) Sanctions.

81.18(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director’s designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

(1) The number of assessments willingly and knowingly falsified.

- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
- (5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) *Use of independent assessors.* If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

- (1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.
- (2) The facility's response to the falsification of or causing resident assessments to be falsified.
- (3) The method used to prepare facility staff to do resident assessments.
- (4) The number of individuals involved in the falsification.
- (5) The number of falsified resident assessments.
- (6) The extent of harm to residents caused by the falsifications.

b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

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

441—81.19 Reserved.

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:

81.20(1) Out-of-state providers. Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

81.20(3) Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

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

[ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.21(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.
[ARC 6226C, IAB 3/9/22, effective 5/1/22]

441—81.24 to 81.30 Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

“CMS” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“Deficiency” means a nursing facility’s failure to meet a participation requirement.

“Department” means the Iowa department of human services.

“Immediate jeopardy” means a situation in which immediate corrective action is necessary because the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“*New admission*” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

441—81.32(249A) General provisions.

81.32(1) Purpose of remedies. The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) Basis for imposition and duration of remedies. The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) Number of remedies. The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) Plan of correction requirement.

a. Except as specified in paragraph “*b*,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) Disagreement regarding remedies. If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) Notification requirements.

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

b. Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

81.32(7) Informal dispute resolution.

a. Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

b. Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

c. If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

d. Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

81.33(2) Determining seriousness of deficiencies. To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

a. Whether a facility's deficiencies constitute:

- (1) No actual harm with a potential for minimal harm.
- (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
- (3) Actual harm that is not immediate jeopardy.
- (4) Immediate jeopardy to resident health or safety.

b. Whether the deficiencies:

- (1) Are isolated.
- (2) Constitute a pattern.
- (3) Are widespread.

81.33(3) Other factors which may be considered in choosing a remedy within a remedy category. Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.

b. The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) Available remedies. In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) Selection of remedies.

81.35(1) Categories of remedies. Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) Application of remedies. After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3) "a," 81.35(4) "a," and 81.35(5) "a," for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3) "b," 81.35(4) "b," and 81.35(5) "b," as applicable.

81.35(3) Category 1.

a. Category 1 remedies include the following:

- (1) Directed plan of correction.
- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) Category 2.

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) Category 3.

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) *Plan of correction.*

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) *Appeal of a determination of noncompliance.*

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.

81.36(1) *Terminate agreement or appoint temporary manager.* If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) Other remedies. The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) Notification of CMS. In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) Transfer of residents. The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) Notification of physicians and state board. If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) Termination of agreement or limitation of participation. If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;

b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and

c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) Termination. If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

81.37(3) Denial of payment. Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) Failure to comply. The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).

b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) Repeated noncompliance. For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) Standard surveys to which this provision applies. Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) Program participation.

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

- (1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.
- (2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) Compliance. Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

- (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
- (2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) Qualifications. The temporary manager must:

- a.* Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.
- b.* Not have been found guilty of misconduct by any licensing board or professional society in any state.
- c.* Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.
- d.* Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) Payment of salary. The temporary manager's salary:

- a.* Is paid directly by the facility while the temporary manager is assigned to that facility.
- b.* Shall be at least equivalent to the sum of the following:
 - (1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.
 - (2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.
 - (3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.
- c.* May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) Failure to relinquish authority to temporary management.

a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).

b. A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) Duration of temporary management. Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.

81.40(1) Optional denial of payment. Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) Required denial of payment. Payment for all new admissions shall be denied when:

a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) *Resumption of payments.* Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) *Resumption of payments.* No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) *Restriction.* No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) Secretarial authority to deny all payments.

81.41(1) *CMS option to deny all payment.* If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) *Resumption of payment.* When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) State monitoring.

81.42(1) *State monitor.* A state monitor:

a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

b. Is an employee or a contractor of the department of inspections and appeals.

c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

d. Is not an employee of the facility.

e. Does not function as a consultant to the facility.

f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) *Use of state monitor.* A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) *Discontinuance of state monitor.* State monitoring is discontinued when:

a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

b. Termination procedures are completed.

441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) Required training. The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

- a. The facility has a pattern of deficiencies that indicate noncompliance; and
- b. Education is likely to correct the deficiencies.

81.44(2) Action following training. After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) Payment. The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) Closure during an emergency. In an emergency, the department and the department of inspections and appeals have the authority to:

- a. Transfer Medicaid and Medicare residents to another facility; or
- b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) Required transfer in immediate jeopardy situations. When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) All other situations. Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) When facility requests a hearing.

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) When facility does not request a hearing. If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(3) When facility waives a hearing. If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

- a. Achieves substantial compliance; or
- b. Is terminated.

81.47(4) Accrual and computation of penalties. Accrual and computation of penalties for a facility that:

- a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);
- b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) Collection. The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) Waiver of a hearing. The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) Reduction of penalty amount.

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) Amount of penalty. The penalties are within the following ranges, set at \$50 increments:

a. Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) "b."

b. Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) Basis for penalty amount. The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

81.50(3) Decreased penalty amounts. Except as specified in 81.50(4) "b," if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) Increased penalty amounts.

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) Review of the penalty. When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

- a.* Set a penalty of zero or reduce a penalty to zero.

b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) Factors affecting the amount of penalty. In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

a. The facility's history of noncompliance, including repeated deficiencies.

b. The facility's financial condition.

c. The factors specified in rule 441—81.33(249A).

d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

81.50(7) Authority to settle penalties. The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) When penalty begins to accrue. The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) Duration of penalty. The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;

b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or

c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) Penalty due. The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) Notice after facility achieves compliance. When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

a. The amount of penalty per day;

b. The number of days involved;

c. The total amount due;

d. The due date of the penalty; and

e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) Notice to terminated facility. In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

a. Final administrative decision is made;

b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or

c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) Accrual of penalties when there is no immediate jeopardy.

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph "a," if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) Accrual of penalties when there is immediate jeopardy.

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) Documenting substantial compliance.

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.

81.52(1) When payments are due.

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

- (1) The facility achieves substantial compliance before the final administrative decision; or
- (2) The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

- (1) The facility achieves substantial compliance before the hearing request was due; or
- (2) The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

- (1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
- (2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:

- (1) The final administrative decision is made before the facility came into compliance;
- (2) The facility did not file a timely hearing request before it came into substantial compliance; or
- (3) The facility waived its right to a hearing before it came into substantial compliance.

e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

- (1) The final administrative decision was made;
- (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
- (3) The facility waived its right to a hearing.

f. In the cases specified in paragraph “*d.*” the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) Deduction of penalty from amount owed. The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) Interest. Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.53(249A) Use of penalties collected by the department. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;

2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

[ARC 9402B, IAB 3/9/11, effective 4/1/11; ARC 3717C, IAB 3/28/18, effective 7/1/18]

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) Criteria.

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

- (1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;
- (2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and
- (3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1) “*a*” are not met.

81.54(2) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1) “*a*” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) Period of continued payments. If the conditions in 81.54(1) “*a*” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) Failure to achieve substantial compliance. If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) Disagreement over whether facility has met requirements.

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:

- (1) CMS finds the facility is in substantial compliance with the participation requirements; and
- (2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:

- (1) CMS finds that a facility has not achieved substantial compliance; and
- (2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS’s survey findings take precedence, CMS may:

- (1) Impose any of the alternative remedies specified in rule 441—81.34(249A);
- (2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and
- (3) Stop federal financial participation to the department for a nursing facility.

81.55(2) Disagreement over decision to terminate.

- a.* CMS's decision to terminate the participation of a facility takes precedence when:
- (1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and
 - (2) CMS, but not the department of inspections and appeals, finds that the facility's participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.
- b.* The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:
- (1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and
 - (2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

81.55(3) *Disagreement over timing of termination of facility.* The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

- a.* A facility is not in substantial compliance; and
- b.* The facility's participation should be terminated.

81.55(4) *Disagreement over remedies.*

a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

- (1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and
 - (2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.
- b.* When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) *One decision.* Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) *Remedies continue.* Except as specified in subrule 81.56(2), alternative remedies continue until:

- a.* The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or
- b.* The provider agreement is terminated.

81.56(2) *State monitoring.* In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

- a.* The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
- b.* The provider agreement is terminated.

81.56(3) *Temporary management.* In the case of temporary management, the remedy continues until:

- a.* The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;
- b.* The provider agreement is terminated; or

c. The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) Facility in compliance. If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) Termination of provider agreement.

81.57(1) Effect of termination. Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) Basis of termination.

a. A facility's provider agreement may be terminated if a facility:

- (1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or
- (2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

b. A facility's provider agreement shall be terminated if a facility:

- (1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or
- (2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1)“a.”

81.57(3) Notice of termination. Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

a. At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

b. At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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

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- ¹ Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
- ² Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
- ³ Effective date of 81.13(7) “c”(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- ⁴ Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA JUVENILE HOME
[Prior to 7/1/83, Social Services[770] Ch 101]
[Prior to 2/11/87, Human Services[498]]
Rescinded **ARC 6225C**, IAB 3/9/22, effective 5/1/22

CHAPTER 102
Reserved

PUBLIC SAFETY DEPARTMENT[661]

Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

CHAPTER 1 THE DEPARTMENT

- | | |
|----------|---|
| 1.1(17A) | Establishment of the department of public safety |
| 1.2(17A) | Organization |
| 1.3(17A) | Offices |
| 1.4(17A) | Methods by which and location where the public may obtain information or make submissions or requests |
| 1.5 | Reserved |
| 1.6(17A) | Legal advice |
| 1.7(17A) | Surety companies |
| 1.8(17A) | Construction of rules |

CHAPTER 2 Reserved

CHAPTER 3 SHERIFF'S UNIFORMS

- | | |
|---------------|--------------------|
| 3.1(17A,331) | General provisions |
| 3.2(17A,331) | Trousers |
| 3.3(17A,331) | Shirts |
| 3.4(17A,331) | Hats |
| 3.5(17A,331) | Ties |
| 3.6(17A,331) | Raingear |
| 3.7(17A,331) | Shoes and boots |
| 3.8(17A,331) | Gloves |
| 3.9(17A,331) | Jackets |
| 3.10(17A,331) | Accessories |

CHAPTERS 4 and 5 Reserved

CHAPTER 6 VEHICLE IMPOUNDMENT

- | | |
|--------------|--|
| 6.1(17A,321) | Vehicle impoundment |
| 6.2(17A,321) | Vehicles which may be impounded immediately |
| 6.3(17A,321) | Vehicles which need not be impounded immediately |
| 6.4(17A,321) | Impoundment procedure |
| 6.5(17A,321) | Abandoned vehicles |
| 6.6(321) | Scope |

CHAPTER 7 Reserved

CHAPTER 8 CRIMINAL JUSTICE INFORMATION

- | | |
|--------------|----------|
| 8.1 to 8.100 | Reserved |
|--------------|----------|

DIVISION I IOWA ON-LINE WARRANTS AND ARTICLES SYSTEM

- | | |
|---------------|---|
| 8.101(80,692) | Iowa on-line warrants and articles (IOWA) criminal justice information system |
| 8.102(80,692) | Information available through the IOWA system |

- 8.103(80) Human immunodeficiency virus-related information
- 8.104(80,692) IOWA system security
- 8.105(80,692) Subpoenas and court orders

CHAPTER 9

Reserved

CHAPTER 10

PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF PUBLIC SAFETY

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- 10.2 to 10.100 Reserved

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- 10.101(17A) Petition for declaratory order
- 10.102(17A) Notice of petition
- 10.103(17A) Intervention
- 10.104(17A) Briefs
- 10.105(17A) Inquiries
- 10.106(17A) Service and filing of petitions and other papers
- 10.107(17A) Consideration
- 10.108(17A) Action on petition
- 10.109(17A) Refusal to issue order
- 10.110(17A) Contents of declaratory order—effective date
- 10.111(17A) Copies of orders
- 10.112(17A) Effect of a declaratory order
- 10.113 to 10.200 Reserved

AGENCY PROCEDURE FOR RULE MAKING

- 10.201(17A) Applicability
- 10.202(17A) Advice on possible rules before notice of proposed rule adoption
- 10.203(17A) Public rule-making docket
- 10.204(17A) Notice of proposed rule making
- 10.205(17A) Public participation
- 10.206(17A) Regulatory analysis
- 10.207(17A,25B) Fiscal impact statement
- 10.208(17A) Time and manner of rule adoption
- 10.209(17A) Variance between adopted rule and published notice of proposed rule adoption
- 10.210(17A) Exemptions from public rule-making procedures
- 10.211(17A) Concise statement of reasons
- 10.212(17A) Contents, style, and form of rule
- 10.213(17A) Agency rule-making record
- 10.214(17A) Filing of rules
- 10.215(17A) Effectiveness of rules prior to publication
- 10.216(17A) General statements of policy
- 10.217(17A) Review by department of rules
- 10.218(17A) Petition for rule making
- 10.219(17A) Briefs
- 10.220(17A) Inquiries
- 10.221(17A) Agency consideration
- 10.222(17A) Waivers of rules
- 10.223 to 10.300 Reserved

CONTESTED CASES

10.301(17A)	Scope and applicability
10.302(17A)	Definitions
10.303(17A)	Time requirements
10.304(17A)	Requests for contested case proceeding
10.305(17A)	Notice of hearing
10.306(17A)	Presiding officer
10.307(17A)	Waiver of procedures
10.308(17A)	Telephone proceedings
10.309(17A)	Disqualification
10.310(17A)	Consolidation—severance
10.311(17A)	Pleadings
10.312(17A)	Service and filing of pleadings and other papers
10.313(17A)	Discovery
10.314(17A)	Subpoenas
10.315(17A)	Motions
10.316(17A)	Prehearing conference
10.317(17A)	Continuances
10.318(17A)	Withdrawals
10.319(17A)	Intervention
10.320(17A)	Hearing procedures
10.321(17A)	Evidence
10.322(17A)	Default
10.323(17A)	Ex parte communication
10.324(17A)	Recording costs
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10.327(17A)	Appeals and review
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10.329(17A)	Stays of agency actions
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10.331(17A)	Emergency adjudicative proceedings
10.332(17A)	Burden of proof

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13.2(17A,80)	Standards
13.3(17A,80)	Training requirements
13.4(17A,80)	Letter of request
13.5(17A,80)	Application form
13.6(17A,80)	Photographs
13.7(17A,80)	Vision classification
13.8(17A,80)	Surety bond
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CHAPTER 35
COMPLAINTS AGAINST EMPLOYEES

[Prior to 11/8/06, see 661—Ch 9]

661—35.1(80) Definitions. The following definitions apply to rules 661—35.1(80) through 661—35.4(80):

“*Complaint*” means a formal written allegation signed by the complainant, or a signed written statement by an officer receiving an oral complaint stating the complainant’s allegation regarding, but not limited to, breach of rules or orders, a violation of the law, or other misconduct by an employee of the department.

“*Department*” means the Iowa department of public safety.

“*Employee*” means any employee of the department.

[ARC 6230C, IAB 3/9/22, effective 4/13/22]

661—35.2(80) Filing a complaint.

35.2(1) Any person may file a complaint against an employee or employees by:

a. Mailing a signed complaint in writing to the professional standards bureau at the following address:

Professional Standards Bureau
Iowa Department of Public Safety
Oran Pape State Office Building
215 East 7th Street
Des Moines, Iowa 50319

Complaints in writing may be mailed or submitted to any office of the department.

b. Calling the professional standards bureau at (515)725-6270, or by calling any office of the department.

c. Completing the commendation/complaint form online on the website of the department.

NOTE: The complaint form may be found at the following location:
[stateofiowa.seamlessdocs.com/f/PSB Complaint Form](http://stateofiowa.seamlessdocs.com/f/PSB%20Complaint%20Form).

35.2(2) The complainant should describe as specifically and completely as possible the nature of the complaint and the details of any incident or incidents which give rise to the complaint.

35.2(3) Each complaint received will be recorded and investigated.

35.2(4) The complainant need not be identified if a statement is received as an oral complaint.

Anonymous complaints will be accepted and investigated as thoroughly as possible.

[Editorial change: IAC Supplement 6/17/09; Editorial change: IAC Supplement 9/8/21; ARC 6230C, IAB 3/9/22, effective 4/13/22]

661—35.3(80) Notification to complainant. The professional standards bureau shall provide any identified complainant with a written receipt of the complaint and may provide additional information regarding the complaint and its disposition as permitted by law.

661—35.4(80) Investigation requirements of agency.

35.4(1) *Recordkeeping and release of information.* The department shall keep confidential an officer’s statement, recordings or transcripts of any interviews or disciplinary proceedings, and any complaints made against an officer unless otherwise provided by law or with the officer’s written consent. Nothing in this rule prohibits the release of an officer’s statement, recordings or transcripts of any interviews or disciplinary proceedings, and any complaints made against an officer to the officer or the officer’s legal counsel upon the officer’s request.

35.4(2) *Training of investigating employee.* The department shall provide training to any officer or supervisor who performs or supervises an investigation under Iowa Code section 80F.1, and shall maintain documentation of any related training. The Iowa law enforcement academy shall adopt minimum training standards consistent with this rule, including training standards concerning interviewing an officer subject to a complaint.

35.4(3) *Right of officer to personnel file and records.* Upon written request, the department shall provide to the requesting officer or the officer's legal counsel a copy of the officer's personnel file and training records regardless of whether the officer is subject to a formal administrative investigation at the time of the request.

This rule is intended to implement Iowa Code sections 80F.1(20) through 80F.1(22).
[ARC 6230C, IAB 3/9/22, effective 4/13/22]

These rules are intended to implement Iowa Code chapter 80.

[Filed 6/7/79, Notice 5/2/79—published 6/27/79, effective 8/2/79]

[Filed 4/1/88, Notice 9/23/87—published 4/20/88, effective 5/25/88]

[Filed 10/19/06, Notice 9/13/06—published 11/8/06, effective 1/1/07]

[Editorial change: IAC Supplement 6/17/09]

[Editorial change: IAC Supplement 9/8/21]

[Filed ARC 6230C (Notice ARC 6052C, IAB 11/17/21), IAB 3/9/22, effective 4/13/22]

CHAPTER 80
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
[Prior to 2/11/09, see 661—Ch 25]

PREAMBLE

Scope. These rules are to provide notice of how the department keeps records and what the procedures are for access by the public. Nothing in these rules affects the access of information by law enforcement agencies, agencies of government or persons authorized by chapter 692 of the Iowa Code to receive information.

661—80.1(17A,22) Definition. As used in this chapter:

“Agency” means the “department of public safety.”

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.2(17A,22) Statement of policy. The purpose of this chapter is to facilitate broad public access to open records. It also seeks to facilitate sound agency determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This agency is committed to the policies set forth in Iowa Code chapter 22; agency staff shall cooperate with members of the public in implementing the provisions of that chapter.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.3(17A,22) Requests for access to records.

80.3(1) Location of record. A request for access to a record should be directed to the office where the record is kept. If the location of the record is not known by the requester, the request shall be directed to the Public Information Bureau, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319.

80.3(2) Office hours. Open records shall be made available during customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays, and legal holidays.

80.3(3) Request for access. A request for access to open records may be made in writing, by electronic mail, in person, or by telephone. The request shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

80.3(4) Response to requests. Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing. The custodian shall also provide to the requester an estimate of any fees which will be assessed to cover the costs of complying with the request.

80.3(5) Security of record. No person may, without permission from the custodian, search or remove any record from agency files. Examination and copying of agency records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

80.3(6) Copying. A reasonable number of copies of an open record may be made in the departmental office. If photocopy equipment is not available in the departmental office where an open record is kept, the custodian shall permit its examination in that office or a nearby location and shall arrange to have copies promptly made elsewhere. An electronic copy may be provided if mutually agreeable to the custodian and the requester.

80.3(7) Fees.

a. When charged. The agency may charge fees in connection with the examination or copying of records only if the fees are authorized by law. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for published materials and for photocopies of records supplied by the agency shall be prominently posted in agency offices. Copies of records may be made by or for members of the public on agency photocopy machines or from electronic storage systems at cost as determined and posted in agency offices by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

c. Search and supervisory fees. Fees may be charged for actual agency expenses in searching for and supervising the examination and copying of requested records. The custodian shall notify the requester of the hourly fees to be charged for searching for records and supervision of records during examination and copying. That hourly fee shall not be in excess of the hourly wage of an agency employee who ordinarily would be appropriate and suitable to perform these search and supervisory functions.

d. Advance deposits.

(1) When the estimated total fee chargeable under this subrule exceeds \$25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

(2) When a requester has previously failed to pay a fee chargeable under this subrule, the custodian may require payment of the full amount of any fees previously owed and of any estimated fees for the new request prior to processing any new request from the requester.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.4(17A,22) Procedures for access to confidential records. This rule contains the provisions governing public access to confidential records in addition to those specified for all records in rule 661—80.3(17A,22). These provisions do not apply to law enforcement agencies, agencies of government or persons authorized by Iowa Code chapter 692 or 100A to receive confidential information.

80.4(1) Proof of identity. A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

80.4(2) Requests. The custodian may require a request to examine and copy a confidential record to be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

80.4(3) Reserved.

80.4(4) Request denied. When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

a. The name and title or position of the custodian responsible for the denial; and

b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

80.4(5) Request granted. When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.5(17A,22) Requests for treatment of a record as a confidential record.

80.5(1) Any person who would be substantially or irreparably injured by disclosure of all or a part of a record to members of the public may file a request, as provided in this rule, for its treatment as a confidential record. Failure of a person to request confidential record treatment for all or part of a record does not preclude the agency from treating it as a confidential record.

80.5(2) A request for the treatment of a record as a confidential record shall be in writing and shall be filed with the custodian of that record. The request shall include an enumeration of the specific grounds upon which examination would not be in the public interest; the specific provisions of law that authorize confidential record treatment; and the name, address, and telephone number of the person authorized to respond to any agency action concerning the request. A person filing a request shall, if possible, accompany the request with a copy of the record in question from which those portions for which confidential record treatment has been requested have been deleted. If the original record is being submitted to the agency by the person requesting confidentiality at the same time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are a confidential record. Requests for treatment of all or portions of a record as a confidential record for a limited time period shall also specify the precise period of time for which confidential record treatment is requested.

80.5(3) Failure to request. Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the agency does not request that it be withheld from public inspection under Iowa Code sections 22.7(3) and 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

80.5(4) Timing of decision. A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

80.5(5) Request granted or deferred. If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

80.5(6) Request denied. If a request for confidential record treatment is denied, the requester may seek review or relief under Iowa Code section 22.8.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.6(17A,22) Procedure by which a subject may have additions, dissents, or objections entered into the record. Except as otherwise provided by law, the subject of a record shall have the right to have a written statement of additions, dissents, or objections entered into the record. The subject shall send the statement to the custodian of the record. The statement must be dated and signed by the subject, and shall include the current address and telephone number of the subject or the subject's representative.

EXCEPTION: This rule does not apply to criminal investigation, identification or intelligence files. Access to criminal history data shall be governed by Iowa Code section 692.5.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.7(17A,22) Consent to disclosure by the subject of a confidential record. The subject of a confidential record may consent to agency disclosure to a third party of that portion of the record concerning the subject. The consent must be in writing and must identify the particular record or records that may be disclosed, the particular person, or class of persons, to whom the record may be disclosed, and where applicable, the time period during which the record may be disclosed. The subject and, where applicable, the person to whom the record is to be disclosed may be required to provide proof of identity.

EXCEPTION: This rule does not apply to criminal investigation, identification or intelligence files. Access to criminal history data shall be governed by Iowa Code section 692.5.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.8 Reserved.

661—80.9(17A,22) Disclosures without the consent of the subject.

80.9(1) Open records are routinely disclosed without the consent of the subject.

80.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 661—80.10(17A,22) or in any notice for a particular record system.

b. To a recipient who has provided the agency with advance written assurance that the record will be used solely as a statistical research or reporting record; provided, that, the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if an authorized representative of such government agency or instrumentality has submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last known address of the subject.

e. To the legislative services agency.

f. Disclosures in the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.10(17A,22) Routine use.

80.10(1) Defined. “Routine use” means the disclosure of a record without the consent of the subject or subjects, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

80.10(2) To the extent allowed by law, the following uses are considered routine uses of all agency records:

a. Disclosure to those officers, employees, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may upon request of any officer or employee, or on the custodian’s own initiative, determine what constitutes legitimate need to use confidential records.

b. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

c. Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the agency.

d. Transfers of information within the agency, to other state agencies, or to local units of government as appropriate to administer the program for which the information is collected.

e. Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the agency is operating a program lawfully.

f. Any disclosure specifically authorized by the statute under which the record was collected or maintained.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.11(17A,22) Records retention manual. The department’s “Records Retention Manual” contains the records management information required by Iowa Code chapter 22. The manual is available for examination and copying at the Public Information Bureau, Department of Public Safety, State Public Safety Headquarters Building, 215 East 7th Street, Des Moines, Iowa 50319.

[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.12(17A,22) Data processing system. All departmental data processing systems that have common data elements can potentially match, collate or compare personally identifiable information.
[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.13(22) Confidential records. This rule describes the types of departmental information or records that are confidential, in addition to those listed in Iowa Code chapter 22. This rule is not exhaustive.

1. Investigative reports including laboratory reports. (Iowa Code sections 22.7, 622.11, 692.2)
2. Criminal histories. (Iowa Code sections 22.7, 622.11, 692.2)
3. Intelligence reports. (Iowa Code sections 22.7, 622.11, 692.2)
4. Domestic abuse reports. Information which individually identifies perpetrators or victims of domestic abuse. (Iowa Code sections 22.7, 236.9)
5. Radio communication log where it contains criminal history and intelligence information. (Iowa Code sections 22.7, 692.2)
6. Personal information in confidential personnel files including but not limited to evaluations, discipline, social security numbers, medical and psychological evaluations.
7. Complaint files, investigative files and similar information relating to private investigative agency licensees. (Iowa Code sections 22.7, 80A.17)
8. Records received from other agencies which would be confidential if created by the department. (Iowa Code sections 22.7, 692.2, 692.3)
9. Any report, manual, or other record which contains information concerning security procedures or emergency preparedness information related to the protection of employees of the department, employees of other agencies of state government, employees of other units of government, visitors to state government facilities or offices, other persons on premises controlled by any state or local government agency, or property owned by or under the control of the department, any other state agency, or any other unit of government, or information concerning security procedures or emergency preparedness information related to persons or property owned by or under the control of a private entity if that information was obtained by the department in relation to planning for emergencies or developing security procedures, or with an assurance that the information would be maintained as confidential.
[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.14(252J) Release of confidential licensing information for child support recovery purposes. Notwithstanding any statutory confidentiality provision, the department may share information with the child support recovery unit of the Iowa department of human services through manual or automated means for the sole purpose of identifying licensees or applicants subject to enforcement of child support orders pursuant to Iowa Code chapter 252J or 598.
[ARC 7562B, IAB 2/11/09, effective 4/1/09]

661—80.15(22,80F) Release of official photographs of or personal information about employees.

80.15(1) An official photograph of or personal information about an employee of the department who is an officer as defined in Iowa Code section 80F.1 shall be released only if either of the following is true:

- a. The employee has signed a written release giving permission to release the photograph or personal information; or
- b. A request has been received to release the photograph or personal information pursuant to Iowa Code chapter 22.

80.15(2) A photograph of or personal information about any employee of the department shall not be released if its release could jeopardize an ongoing investigation or place the employee at risk.

80.15(3) An officer's personal information, including but not limited to the officer's home address, personal telephone number, personal electronic mail address, date of birth, social security number, and

driver's license number, shall be confidential and redacted prior to a record's release to the public by the department.

[ARC 7562B, IAB 2/11/09, effective 4/1/09; ARC 6230C, IAB 3/9/22, effective 4/13/22]

These rules are intended to implement Iowa Code chapters 22 and 80F.

[Filed 4/29/88, Notice 3/23/88—published 5/18/88, effective 7/1/88]

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[Filed ARC 7562B (Notice ARC 6916B, IAB 7/2/08), IAB 2/11/09, effective 4/1/09]

[Filed ARC 6230C (Notice ARC 6052C, IAB 11/17/21), IAB 3/9/22, effective 4/13/22]

REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, chapter 1245.

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[Prior to 12/17/86, Revenue Department[730]]

701—42.1(257,422) School district surtax. Iowa law provides for the implementation of an income surtax for increasing local school district budgets. The surtax must be approved by the voters of a school district in a special election or by a resolution of the board of directors of a school district. The surtax rate is determined by the department of management on the basis of the revenue to be raised by the surtax for the particular school district with the surtax.

The school district surtax is imposed on the income tax liabilities of all taxpayers residing in the school district on the last day of the taxpayers' tax years. For purposes of the school district surtax, income tax liability is the tax computed under Iowa Code section 422.5, less the nonrefundable credits against computed tax which are authorized in Iowa Code chapter 422, division II.

In a situation where an individual is residing in a school district with a surtax and the individual dies during the tax year, the individual will be considered to be subject to the surtax, since the individual was residing in the school district on the last day of the individual's tax year.

An individual serving in the Armed Forces of the United States who maintains permanent residence in an Iowa school district with a surtax is subject to the surtax regardless of whether the individual is physically residing in the school district on the last day of the tax year.

A person who is present in the school district on the last day of the tax year on a temporary basis due to annual leave or in transit between duty stations is not subject to the surtax.

This rule is intended to implement Iowa Code sections 257.21, 257.29, and 422.15.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.2(422D) Emergency medical services income surtax. Effective July 1, 1992, a county board of supervisors may offer for voter approval a local option income surtax, an ad valorem property tax, or a combination of the two taxes to generate revenues for emergency medical services. However, this rule pertains only to the local option income surtax for emergency medical services. If a majority of those voting in the election approve the emergency medical services income surtax, the income surtax will be imposed for tax years beginning on or after January 1 of the fiscal year in which the election is held. Thus, if an election is held in the 2007-2008 fiscal year (July 1, 2007, through June 30, 2008) and the income surtax is approved in the election, the income surtax will be imposed on 2008 returns for individuals filing on a calendar-year basis. In the case of individuals filing on a fiscal-year basis, the income surtax will be imposed on returns for tax years beginning in the 2008 fiscal year. If an emergency medical services income surtax is imposed for a county, it can be imposed only for a maximum period of five years. When the emergency medical income surtax is repealed because the five-year imposition has expired, the income surtax is repealed as of December 31 for tax years beginning on or after that date.

42.2(1) *The rate of the income surtax imposed for emergency medical services.* After the income surtax is approved by an election of county voters, the board of supervisors will set the rate of tax to be imposed, which can be expressed in tenths of 1 percent or hundredths of 1 percent but cannot exceed 1 percent. In addition, because the cumulative total of the percents of income surtax imposed on any taxpayer in the county cannot exceed 20 percent, the rate of an emergency medical services income surtax may be limited, if a school district income surtax has been approved previously by a school district in the county and the surtax rate exceeds 19 percent. Therefore, assuming that a school district in the county had previously approved an income surtax rate of 19.4 percent, the medical emergency income surtax rate would be limited to six-tenths of 1 percent. If a school district income surtax and emergency medical income surtax are approved on or about the same date and the cumulative total of the income surtaxes is greater than 20 percent, the income surtax approved on the earlier of the two dates will be allowed at the rate approved and the second income surtax approved will be limited accordingly so that the cumulative rate will not exceed 20 percent. If a school district income surtax and an emergency medical income surtax are approved on the same date with a proposed cumulative rate that exceeds 20 percent, each of the surtaxes will be reduced equally so that the cumulative surtax rate will not exceed 20 percent. Assuming that a school district in a particular county approves an income surtax of 20 percent

on November 4, 2008, and an emergency medical income surtax of 1 percent is approved on the same date, both surtaxes will be reduced by five-tenths of 1 percent so that the cumulative rate of the two income surtaxes does not exceed 20 percent. The department of management can provide information about any income surtaxes that have been approved for the school districts in the county.

42.2(2) *Imposing the emergency medical income surtax.* The emergency medical income surtax will be imposed on the state income tax liability on each individual residing in the county at the end of the individual's tax year, whether the individual's tax year ends at the end of the calendar year or fiscal year. For purposes of the emergency medical income surtax, an individual's income tax liability is the aggregate of the state income taxes determined in Iowa Code section 422.5 less the nonrefundable credits against computed income tax which are authorized in Iowa Code chapter 422, division II.

42.2(3) *Administering the emergency medical income surtax.* The director of revenue shall administer the emergency medical income surtax in the same way as other state individual tax laws are administered. All powers and requirements related to administering the state income tax law apply to the administration of the emergency medical income surtax including, but not limited to, the provisions of Iowa Code sections 422.4, 422.20 to 422.31, 422.68, 422.70, and 422.72 to 422.75. The county board of supervisors and county officials shall confer with the director for assistance in drafting the ordinance imposing the emergency medical income surtax. Certified copies of the ordinance shall be filed with the department of revenue and the department of management within 30 days after the emergency medical income surtax is approved.

42.2(4) *Accounting for the emergency medical income surtax and paying the surtax.* The department shall account for the emergency medical income surtax and any interest and penalties on the surtax so that there is a separate accounting for each county where the income surtax is imposed. The accounting shall be applicable to those individual income tax returns filed on or before November 1 of the calendar year following the tax year for which the tax is imposed. The emergency medical income surtax and any penalties and interest should be credited to a "local income surtax fund" established in the office of the state treasurer. On or before December 15 of the year after the tax year, the director of revenue shall certify to the state treasurer the income surtax and any interest and penalties collected from returns filed on or before November 1.

This rule is intended to implement Iowa Code chapter 422D.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.3(422) Exemption credits.

42.3(1) A single person shall deduct from the computed tax a personal exemption credit of \$40. A single person is defined in 701—subrule 39.4(1).

42.3(2) A married person living with husband or wife at the close of the taxable year, or living with husband or wife at the time of the death of that spouse during the taxable year, shall, if a joint return is filed, deduct from the computed tax a personal exemption of \$80. Where such spouse files a separate return, each spouse is entitled to deduct from the computed tax a personal exemption of \$40. The personal exemption may not be divided between the spouses in any other proportion.

42.3(3) A taxpayer shall deduct from computed tax an exemption of \$40 for each dependent. "Dependent" has the same meaning as provided by the Internal Revenue Code, and the same dependents shall be claimed for Iowa income tax purposes as the taxpayer is entitled to claim for federal income tax purposes. If each spouse furnished 50 percent of the support, the spouses must elect between them which spouse is to be entitled to claim the dependent. The dividing of dependent credits applies only to the number of dependents and not to the credit amount for a particular dependent.

42.3(4) A head of household as defined in 701—subrule 39.4(7) is allowed a personal exemption credit of \$80.

42.3(5) A taxpayer who is 65 years of age on or before the first day following the end of the tax year is allowed an additional personal exemption credit of \$20 in addition to any other credits allowed by this rule.

42.3(6) A taxpayer who is blind, as defined in Iowa Code section 422.12(1) "e," is allowed a personal exemption credit of \$20 in addition to any other credits allowed by this rule.

42.3(7) A nonresident taxpayer or a part-year resident taxpayer will be allowed to deduct personal exemption credits as if the nonresident taxpayer or part-year taxpayer was a resident for the entire year.

This rule is intended to implement Iowa Code section 422.12.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.4(422) Tuition and textbook credit for expenses incurred for dependents attending grades kindergarten through 12 in Iowa. Taxpayers who pay tuition and textbook expenses of dependents who attend grades kindergarten through 12 in Iowa may receive a tax credit of 25 percent of up to \$2,000 (\$1,000 for tax years beginning prior to January 1, 2021) of qualifying expenses for each dependent who receives private instruction, as defined in Iowa Code section 422.12(1)“c,” or attends an elementary or secondary school located in Iowa. A taxpayer whose dependent receives private instruction is only eligible for the tuition and textbook credit for tax years beginning on or after January 1, 2021.

For a taxpayer whose dependent attends an elementary or secondary school, in order for the taxpayer to qualify for the tuition and textbook credit, the elementary school or secondary school that the dependent is attending must meet the standards for accreditation of public and nonpublic schools in Iowa provided in Iowa Code section 256.11. In addition, the school the dependent is attending must not be operated for profit and must adhere to the provisions of the United States Civil Rights Act of 1964, and the provisions of Iowa Code chapter 216, which is known as the Iowa civil rights Act of 1965.

42.4(1) Tuition. For purposes of the tuition and textbook tax credit, “tuition” means any charge for the expense of personnel, buildings, equipment, and materials other than textbooks, and other expenses which relate to the teaching of only those subjects that are legally and commonly taught in public elementary or secondary schools in Iowa. “Tuition” includes charges by a qualified school for summer school classes or for instruction of a child who is physically unable to attend classes at the site of the elementary or secondary school. Expenses paid by a taxpayer, including a taxpayer whose dependent receives private instruction, for equipment and materials other than textbooks must be for equipment and materials required for attendance in Iowa in order to be eligible for the tuition and textbook tax credit. The following are examples of equipment and materials that may qualify for the credit provided they are required for attendance in school or for providing private instruction:

- a. Pocket folders and binders.
- b. Spiral notebooks and loose-leaf paper.
- c. Writing utensils, including pens, pencils, highlighters, colored pencils, crayons, and markers.
- d. Backpacks.
- e. Rulers.
- f. Calculators.
- g. Scissors.
- h. Computers, including rental fees paid to a school for the use of a computer.

“Tuition” does not include charges or fees which relate to the teaching of religious tenets, doctrines, or worship in cases where the purpose of the teaching is to inculcate the religious tenets, doctrines, or worship. In addition, “tuition” does not include amounts paid to an individual or other entity for instruction that is supplementary to elementary or secondary school instruction or private instruction. Amounts paid to an elementary or secondary school or to a person providing private instruction for meals, lodging, or clothing for a dependent do not qualify for the tax credit for tuition. “Tuition” also does not include expenses for Internet services or Internet upgrades to facilitate remote learning.

42.4(2) Textbooks. For purposes of the tuition and textbook tax credit, “textbooks” means books and other instructional materials used to teach only those subjects legally and commonly taught in public elementary and secondary schools in Iowa. “Textbooks” includes fees or charges for required supplies or materials for classes in art, home economics, shop, or similar courses. “Textbooks” also includes books and materials used for extracurricular activities, such as sporting events, musical events, dramatic events, speech activities, driver’s education, or programs of a similar nature.

“Textbooks” does not include amounts paid for books or other instructional materials used in the teaching of religious tenets, doctrines, or worship, in cases where the purpose of the teaching is to inculcate the religious tenets, doctrine, or worship. For tax years beginning before January 1, 2021,

“textbooks” does not include amounts paid for books or other instructional materials used in teaching a dependent subjects in the home or outside of an elementary or secondary school. For tax years beginning on or after January 1, 2021, “textbooks” does include amounts paid for books or other instructional materials used in teaching a dependent subjects in the home or outside of an elementary or secondary school if that dependent is receiving private instruction.

42.4(3) *Extracurricular activities.* For purposes of the tuition and textbook tax credit, amounts paid for dependents to participate in or to attend extracurricular activities may be claimed as part of the tuition and textbook tax credit. “Extracurricular activities” includes sporting events, musical events, dramatic events, speech activities, driver’s education, and programs of a similar nature.

a. The following are specific examples of expenditures related to a dependent’s participation in or attendance at extracurricular activities offered by a qualifying school or offered in the course of private instruction that may qualify for the tuition and textbook tax credit:

- (1) Fees for participation in sports activities.
- (2) Fees for field trips.
- (3) Rental fees for instruments for bands or orchestras but not rental fees in rent-to-own contracts.
- (4) Driver’s education fees.
- (5) Cost of activity tickets or admission tickets to sporting, music, and dramatic events.
- (6) Fees for events such as homecoming, winter formal, prom, or similar events.
- (7) Rental of costumes for plays.
- (8) Purchase of costumes for plays if the costumes are not suitable for street wear.
- (9) Purchase of track shoes, football shoes, or other athletic shoes with cleats, spikes, or other features that are not suitable for street wear.
- (10) Costs of tickets or other admission fees to attend banquets or buffets for academic or athletic awards.
- (11) Trumpet grease, woodwind reeds, guitar picks, violin strings, and similar types of items for maintenance of instruments used in bands or orchestras.
- (12) Band booster club or athletic booster club dues, but only if dues are for the dependent and not the parent or adult.
- (13) Rental of a formal gown or a tuxedo for a dance or similar event.
- (14) Dues paid to clubs or organizations such as chess club, photography club, debate club, or similar organizations.
- (15) Amounts paid for music that will be used in music programs, including vocal music programs.
- (16) Fees paid for required general materials for shop class, agriculture class, home economics class, or auto repair class and general fees for equivalent classes.
- (17) Fees for a dependent’s bus trips to attend school or private instruction if paid to the school or the provider of private instruction.
- (18) Costs of band or athletic uniforms.
- (19) Costs of instrument lessons.

b. The following are specific examples of expenditures related to a dependent’s participation in or attendance at extracurricular activities offered by a school or offered in the course of private instruction that will not qualify for the tuition and textbook credit.

- (1) Purchase of a musical instrument used in a band or orchestra.
- (2) Purchase of basketball shoes or other athletic shoes that are readily adaptable to street wear.
- (3) Amounts paid for special testing such as SAT or PSAT, and for Iowa talent search tests.
- (4) Payments for senior trips, band trips, and other overnight activity trips which involve payment for meals and lodging.
- (5) Fees paid to K-12 schools or to a private instructor for courses for college credit.
- (6) Amounts paid for T-shirts, sweatshirts, and similar clothing that is appropriate for street wear.
- (7) Amounts paid for special programs at universities and colleges.
- (8) Amounts paid for a yearbook, annual, or class ring.
- (9) Fees for special materials paid for shop class, agriculture class, auto repair class, home economics class, and similar classes. For purposes of this paragraph, “special materials” means

materials used for personal projects of the dependents, such as materials to make furniture for personal use, automobile parts for family automobiles, and other materials for projects for personal or family benefit.

(10) Purchase of a formal gown or a tuxedo for a dance or similar event.

(11) Amounts paid for sports-related social events.

42.4(4) Claiming the credit. The credit can only be claimed by the spouse who claims the dependent credit on the Iowa tax return as described in subrule 42.3(3). For example, for divorced or separated parents, only the spouse who claims the dependent credit on the Iowa return can claim the tuition and textbook credit for tuition and textbook expenses for that dependent.

In cases where married taxpayers file separately on a combined return form, the tuition and textbook credit shall be allocated between the spouses in the ratio in which the dependent credit was claimed between the spouses.

EXAMPLE: A married couple has two dependent children and claimed a tuition and textbook credit of \$500 related to both children on their 2011 Iowa return. The taxpayers filed separately on a combined Iowa return form for 2011. One spouse claimed both of the dependent credits on the Iowa return. The \$500 tuition and textbook credit will be claimed by the spouse who claimed the dependent credits on the Iowa return.

EXAMPLE: A married couple has three dependent children and claimed a tuition and textbook credit of \$600 related to all three children on their 2011 Iowa return. The taxpayers filed separately on a combined Iowa return form for 2011. One spouse claimed one dependent credit, and the other spouse claimed two dependent credits on the Iowa return. The spouse who claimed one dependent credit will claim \$200 of the tuition and textbook credit, while the spouse who claimed two dependent credits will claim \$400 of the tuition and textbook credit.

This rule is intended to implement Iowa Code section 422.12.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 6240C, IAB 3/9/22, effective 4/13/22]

701—42.5(422) Nonresident and part-year resident credit. An individual who is a nonresident of Iowa for the entire tax year, or an individual who is an Iowa resident for a portion of the tax year, is allowed a credit against the individual's Iowa income tax liability for the Iowa income tax on the portion of the individual's income which was earned outside Iowa while the person was a nonresident of Iowa. This credit is computed on Schedule IA 126. The following subrules explain how the credit is computed for taxpayers who are nonresidents of Iowa and taxpayers who are part-year residents of Iowa.

42.5(1) Credit calculation for nonresidents of Iowa.

a. Prior to the calculation of the nonresident credit, a nonresident of Iowa shall compute taxable income in the same manner as a full-year Iowa resident. Thus, a nonresident would have the same initial Iowa income tax liability as a full-year Iowa resident taxpayer with the same taxable income before the nonresident credit is computed.

b. The nonresident credit is computed by dividing the taxpayer's Iowa source net income by the taxpayer's total net income. See 701—Chapter 40 to determine a nonresident's Iowa source net income and total net income. This Iowa income percentage is rounded to the nearest tenth of a percent (e.g., 1.2 percent) for tax years beginning before January 1, 2022, and to the nearest ten-thousandth of a percent (e.g., 1.2345 percent) for tax years beginning on or after January 1, 2022. The Iowa income percentage is then subtracted from 100 percent to arrive at the nonresident credit percentage, which represents the percentage of the individual's total income which was earned outside Iowa. The nonresident credit percentage is multiplied by the net Iowa tax to compute the nonresident credit. For purposes of this subrule, "net Iowa tax" means the Iowa regular income tax after reduction for the nonrefundable credits provided in Iowa Code section 422.12.

EXAMPLE 1: A single resident of Nebraska had Iowa source net income of \$15,000 in 2022 from wages earned from employment in Iowa. The rest of this person's income was attributable to sources outside Iowa. This nonresident of Iowa had a total net income of \$40,000 and a taxable income of \$30,000 due to allowable deductions. The Iowa income percentage is computed by dividing the Iowa source net income of \$15,000 by the taxpayer's total net income of \$40,000, which results in a percentage

of 37.5000. This percentage is subtracted from 100 percent, which leaves a nonresident credit percentage of 62.5000.

The Iowa tax before reduction for the nonrefundable credits under Iowa Code section 422.12 is \$1,508. The individual is allowed an exemption credit under Iowa Code section 422.12 of \$40, which leaves a tax amount of \$1,468 (\$1,508 - \$40). When \$1,468 is multiplied by the nonresident credit percentage of 62.5000, a nonresident credit of \$918 is computed.

EXAMPLE 2: A California resident, who was married, had \$20,000 of Iowa source net income in 2022 from an Iowa farm. This individual had an additional \$80,000 in net income that was attributable to sources outside Iowa, but the individual's spouse had no income. The taxpayers had a total net income of \$100,000 and a taxable income of \$70,000 due to allowable deductions.

The taxpayers had an Iowa income tax liability of \$4,583 after application of the personal exemption credits of \$80 under Iowa Code section 422.12. The taxpayers had an Iowa source net income of \$20,000 and a total net income of \$100,000. Therefore, the Iowa income percentage was 20.0000. Subtracting the Iowa income percentage of 20 percent from 100 percent leaves a nonresident credit percentage of 80.0000.

When the Iowa income tax liability of \$4,583 is multiplied by 80 percent, this results in a nonresident credit of \$3,666.

42.5(2) Credit calculation for part-year residents of Iowa.

a. Prior to the calculation of the part-year resident credit, an individual who is a resident of Iowa for part of the tax year shall compute taxable income in the same manner as a full-year Iowa resident. Therefore, a part-year resident would have the same initial Iowa income tax liability as a full-year Iowa resident with the same taxable income before computation of the part-year resident credit.

b. The part-year resident credit for a part-year resident is computed by adding all the individual's net income received while the taxpayer was a resident of Iowa and all the Iowa source net income received during the period of the tax year when the individual was a nonresident of Iowa, and dividing that sum by the taxpayer's total net income. See 701—Chapter 40 to determine a part-year resident's Iowa source net income and total net income. This Iowa income percentage is rounded to the nearest tenth of a percent (e.g., 1.2 percent) for tax years beginning before January 1, 2022, and to the nearest ten-thousandth of a percent (e.g., 1.2345 percent) for tax years beginning on or after January 1, 2022. The Iowa income percentage is then subtracted from 100 percent to arrive at the part-year resident credit percentage, which represents the percentage of the individual's total income which was earned outside of Iowa while a nonresident. The part-year resident credit percentage is multiplied by the net Iowa tax to compute the part-year resident credit. For purposes of this subrule, "net Iowa tax" means the Iowa regular income tax after reduction for the nonrefundable credits provided in Iowa Code section 422.12.

EXAMPLE 3: A single individual was a resident of Nebraska for the first half of 2022 and moved to Iowa on July 1, 2022, to accept a job in Des Moines. This individual earned \$20,000 from wages, \$200 from interest, and \$4,000 from a ranch in Nebraska from January 1, 2022, through June 30, 2022. In the second half of 2022, this person had wages of \$30,000, interest income of \$300, and \$4,000 from the Nebraska ranch. This part-year resident had \$14,000 of allowable deductions.

The part-year resident's total net income was \$58,500 and the Iowa source net income was \$34,300, which includes the Iowa wages, the Nebraska ranch income of \$4,000 earned during the individual's period of Iowa residence, as well as the interest income of \$300 earned during that time of the tax year. The Iowa taxable income for the part-year resident for 2022 was \$44,500 due to allowable deductions of \$14,000 (\$58,500 - \$14,000). The individual's Iowa income percentage was 58.6325, which was determined by dividing the Iowa source income of \$34,300 by the total income of \$58,500. Subtracting the Iowa income percentage of 58.6325 from 100 percent results in a part-year resident credit percentage of 41.3675. The Iowa tax on total income was \$2,529, which was reduced to \$2,489 after subtraction of the personal exemption credit of \$40 under Iowa Code section 422.12.

When \$2,489 is multiplied by the part-year resident percentage of 41.3675, a part-year resident credit of \$1,030 is computed for this part-year resident.

EXAMPLE 4: A single individual moved from Minnesota to Iowa on July 1, 2022. This person earned \$5,000 in income from an Iowa farm in the first half of the tax year and another \$10,000 from this farm

in the second half of the tax year. This person had \$10,000 in wages from employment in Minnesota in the first half of the year and another \$15,000 in wages from employment in Iowa in the second half of the tax year. This person had \$2,000 in interest from a bank in the first half of the year and \$2,000 in interest from a bank in the second half of the tax year.

The part-year resident's total net income was \$44,000 and the Iowa source net income was \$32,000, which consisted of \$15,000 in wages, \$2,000 in interest income, and \$15,000 in income from the Iowa farm. Since the farm was in Iowa, all farm income, including the income received while the individual was not a resident of Iowa, was taxable to Iowa. The individual's Iowa taxable income was \$34,250, which was computed after subtracting \$9,750 in allowable deductions (\$44,000 - \$9,750). The taxpayer's Iowa income tax liability was \$1,757 after subtraction of a personal exemption credit of \$40 under Iowa Code section 422.12.

The taxpayer's Iowa income percentage was 72.7273, which was computed by dividing the Iowa source net income of \$32,000 by the total net income of \$44,000. The part-year resident credit percentage was 27.2727, which was arrived at by subtracting the Iowa income percentage of 72.7273 from 100 percent. The taxpayer's part-year resident credit is \$479. This was determined by multiplying the Iowa income tax liability after personal exemption credit amount of \$1,757 by the part-year resident percentage of 27.2727.

This rule is intended to implement Iowa Code section 422.5.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 6031C, IAB 11/3/21, effective 12/8/21]

701—42.6(422) Out-of-state tax credits.

42.6(1) Definitions. For purposes of this rule:

“*Foreign country*” means any country, other than the United States, and any political subdivision of that country.

“*Income tax*” means any direct tax imposed upon a taxpayer and measured by the taxpayer's income for a specified period of time. The out-of-state jurisdiction's characterization of the tax is not controlling in the department's determination of whether a tax is an income tax. Fees, penalty, and interest paid in connection with an income tax do not qualify. For purposes of this rule, the term “income tax” does not include a minimum tax imposed on preference items.

“*Pass-through entity*” means an entity taxed as a partnership for federal tax purposes, an S corporation, an estate, or a trust other than grantor trusts.

“*Regulated investment company*” means any domestic corporation that meets the requirements of Section 851 of the Internal Revenue Code and that has made a valid election under Section 853 of the Internal Revenue Code to have its shareholders' pro rata share of entity-level income tax paid by the electing corporation be deemed to have been paid by its shareholders. The term “regulated investment company” includes, but is not limited to, a mutual fund.

“*State*” means any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, and any political subdivision thereof.

“*Tiered owner*” means an owner or beneficiary of a pass-through entity that is itself a pass-through entity.

42.6(2) General application.

a. Residents. Iowa residents, including part-year residents, are allowed an out-of-state tax credit against the resident's Iowa income tax liability for income taxes owed and paid by the resident to another state or foreign country on income for which all of the following are true:

(1) The income was derived from sources within the other state or foreign country. In determining whether income is derived from sources within that other state or foreign country, Iowa statutes and rules on the sourcing of a nonresident's income shall govern.

(2) The income is subject to Iowa income tax. Income tax imposed by another state or foreign country on income that is not subject to Iowa income tax does not qualify for the credit.

(3) The income was earned while the taxpayer was an Iowa resident and is included on the resident's Iowa income tax return. The credit is allowable only if the taxpayer files an Iowa income tax return as a resident or part-year resident.

b. Nonresidents. Nonresidents of Iowa shall not claim the out-of-state tax credit.

42.6(3) Rule for pass-through entities.

a. Direct owners.

(1) If the Iowa resident is a direct partner, shareholder, or beneficiary of a pass-through entity that owed and paid entity-level income tax, or income tax on a composite return basis, to another state or foreign country on income derived from sources in that state or foreign country, the resident is allowed to treat the resident's pro rata share of that income tax as paid by the resident for purposes of the out-of-state tax credit, provided the resident's pro rata share of that income flows through to the resident and meets the requirements of paragraph 42.6(2) "a."

(2) The entity-level income tax or composite income tax paid to the other state or foreign country is the net state or foreign income tax actually owed and paid for the tax year on income taxed by that state or foreign country, as properly computed on the pass-through entity's income tax return or composite return (not a withholding return) in the other state or foreign country after reduction for all nonrefundable credits provided to the pass-through entity. Paragraph 42.6(6) "b" provides an additional limitation if the Iowa resident receives a refundable credit in the other state or foreign country for the Iowa resident's share of the income tax owed and paid by the pass-through entity. The resident's pro rata share of entity-level income tax or composite income tax paid by the pass-through entity shall be in the same proportion as the resident's pro rata share of income derived from sources in that state or foreign country, as properly reported on the entity's return in the other state or foreign country.

(3) To qualify, the pass-through entity must provide to the resident a statement identifying the jurisdiction and the resident's pro rata share of the income, income tax liability, and income tax paid in that jurisdiction.

EXAMPLE 1: Partnership W earns \$2,000 of income in state A, which imposes an entity-level income tax directly on the partnership. Partnership W pays \$100 of income tax to state A. Partnership W is owned 50 percent by Partnership X and 50 percent by individual Y, a resident of Iowa. Individual Y receives a statement from Partnership W showing that Partnership W earned \$2,000 of income and paid \$100 of entity-level income tax to state A and that individual Y's pro rata share of that income and entity-level income tax is \$1,000 and \$50, respectively. If that \$1,000 of income from Partnership W is subject to Iowa income tax and included on individual Y's Iowa income tax return as earned while an Iowa resident, individual Y will be entitled to treat the \$50 of income tax paid by Partnership W to state A as paid by individual Y in the computation of Y's out-of-state tax credit.

b. Indirect owners.

(1) If the Iowa resident is an indirect partner, shareholder, or beneficiary of a pass-through entity that paid entity-level income tax, or income tax on a composite return basis, to another state or foreign country on income derived from sources in that state or foreign country, the resident is allowed to treat the resident's pro rata share of that income tax as paid by the resident for purposes of the out-of-state tax credit if both of the following requirements are satisfied:

1. The tiered owner reduces the amount of the paying pass-through entity's income tax that the tiered owner reports to its partners, shareholders, or beneficiaries by the amount of any credit available from that other state or foreign country to the tiered owner for the tax liability of the paying pass-through entity.

2. The resident's pro rata share of that income flows through one or more tiered owners to the resident and meets the requirements of paragraph 42.6(2) "a."

(2) The entity-level income tax or composite income tax paid to the other state or foreign country is the net state or foreign income tax actually owed and paid for the tax year on income taxed by that state or foreign country, as properly computed on the pass-through entity's income tax return or composite tax return (not a withholding return) in the other state or foreign country, after reduction for all nonrefundable credits provided to the pass-through entity, and after further reduction by a tiered owner for any credits provided by that other state or foreign country to the tiered owner for the tax liability of the paying

pass-through entity. Paragraph 42.6(6) “b” provides an additional limitation if the Iowa resident receives a refundable credit in the other state or foreign country for the Iowa resident’s share of the income tax owed and paid by a pass-through entity. The resident’s pro rata share of entity-level income tax or composite income tax paid by the pass-through entity shall be in the same proportion as the resident’s pro rata share of income derived from sources in that state or foreign country, as properly reported on the entity’s return in the other state or foreign country, after flowing through one or more tiered pass-through entities to the resident.

(3) To qualify, the paying pass-through entity must provide to the tiered owner a statement identifying the jurisdiction and the tiered owner’s pro rata share of the income, income tax liability, and income tax paid in that jurisdiction. The tiered owner, in turn, must provide the indirect partner, shareholder, or beneficiary with a statement that includes all of the following information:

1. The jurisdiction to which income tax was paid; the paying pass-through entity and any other tiered owner through which the income flowed; and the indirect partner’s, shareholder’s, or beneficiary’s pro rata share of the paying pass-through entity’s income.

2. The indirect partner’s, shareholder’s, or beneficiary’s pro rata share of the paying pass-through entity’s income tax liability and income tax paid to the other jurisdiction after reduction for any credit available to the tiered owner for the tax liability of the paying pass-through entity. If no such credit was provided to the tiered owner, the statement must include a declaration from the tiered owner to that effect.

EXAMPLE 2: Assume the same facts as Example 1. Partnership X (a tiered owner) receives a statement from Partnership W which shows that W earned \$2,000 of income in state A and paid \$100 of entity-level income tax to state A and that Partnership X’s pro rata share of that income and entity-level income tax is \$1,000 and \$50, respectively. Partnership X is not eligible for a credit in state A for its share of the entity-level income tax paid by Partnership W. Partnership X is owned 50 percent by individual Z, a resident of Iowa. Individual Z then receives a statement from Partnership X indicating that Partnership X was not eligible for a credit for the tax paid by Partnership W, that Z’s pro rata share of Partnership W’s income taxed by state A is \$500, and that Z’s pro rata share of Partnership W’s income tax imposed by and paid to state A is \$25. If that \$500 of income from Partnership W flows through Partnership X to individual Z, is subject to Iowa income tax, and is included on Z’s Iowa income tax return as earned while an Iowa resident, Z will be entitled to treat the \$25 of income tax paid by Partnership W to state A as paid by Z in the computation of Z’s out-of-state tax credit.

EXAMPLE 3: Assume the same facts as Example 2, except that Partnership X (a tiered owner) is eligible for a \$50 credit in state A for its share of the entity-level income tax paid by Partnership W to state A. Partnership X must reduce its share of Partnership W’s entity-level income tax (\$50) that it can report to its partners by the amount of the credit provided by state A for that tax (\$50). Therefore, Partnership X cannot pass Partnership W’s entity-level income tax through to individual Z, and Z cannot treat a pro rata share of Partnership W’s entity-level income tax as paid by Z. However, if Partnership X is itself subject to and pays an entity-level income tax in state A, it may be allowed to pass through, and individual Z may be allowed to treat as paid by Z a pro rata share of the entity-level income tax paid by Partnership X in state A in the same manner as described in paragraph 42.6(3) “a.”

42.6(4) Rule for regulated investment companies. If the Iowa resident is a shareholder of a regulated investment company making an election under Section 853 of the Internal Revenue Code, the resident shareholder is allowed an out-of-state tax credit for the resident shareholder’s pro rata share of entity-level income tax paid to a foreign country or possession of the United States by the regulated investment company and treated as paid by the resident shareholder under Section 853 of the Internal Revenue Code if the income taxed by the foreign country or possession of the United States is also subject to tax in Iowa and is included on the resident shareholder’s Iowa income tax return as earned while an Iowa resident. To qualify, the regulated investment company must provide to the resident shareholder a statement identifying the jurisdiction and the resident shareholder’s pro rata share of the income, income tax liability, and income tax paid in that jurisdiction.

EXAMPLE 4: Individual D is a resident of Iowa and a shareholder of a mutual fund that paid income tax to foreign jurisdictions and that made an election under Section 853 of the Internal Revenue Code. On the annual, year-end tax statement, the mutual fund reported \$2,000 of income to individual D and

\$10 of foreign tax paid with respect to D's income. If that \$2,000 of income from the mutual fund is subject to Iowa income tax and included on individual D's Iowa income tax return as earned while an Iowa resident, D will be entitled to treat the \$10 of income tax paid by the mutual fund to the foreign jurisdictions as paid by D in the computation of D's out-of-state tax credit.

42.6(5) *Computing the out-of-state tax credit—preliminary calculation.*

a. Required form. The tax credit must be computed on the IA 130, Iowa Out-of-State Tax Credit Schedule. Married taxpayers filing separate Iowa returns, or filing separately on a combined Iowa return, must complete a separate IA 130 for each spouse.

b. Computed separately by jurisdiction. The tax credit must be computed separately for each out-of-state jurisdiction. A separate IA 130 is required for each out-of-state jurisdiction. However, separate computations and separate IA 130s are not required for foreign income taxes paid by a regulated investment company.

c. Computed separately by income tax type. The tax credit must be computed separately for regular income tax and special lump-sum distribution tax. If the taxpayer was assessed a special tax on a lump-sum distribution by another state or foreign country, compute the tax credit separately under these rules using only the lump-sum distribution and lump-sum distribution tax imposed in Iowa and imposed in the other state or foreign country. A lump-sum distribution taxed by another state or foreign country shall not be included as part of gross income. A minimum tax or income tax imposed on preference items derived from sources in another state or foreign country are not eligible for the out-of-state tax credit under this rule. For rules on the out-of-state tax credit with respect to minimum tax paid, see rule 701—42.7(422).

d. Full-year Iowa residents. For a taxpayer who is an Iowa resident for the entire tax year, the income tax paid to the other state or foreign country is the sum of the following amounts:

(1) Income tax treated as paid by the resident under subrules 42.6(3) and 42.6(4). The income tax shall be treated as paid by the resident for the tax year that the out-of-state pass-through income is considered taxable Iowa income to the resident.

(2) The net state or foreign income tax actually owed and paid by the resident for the tax year on income qualifying under paragraph 42.6(2) "a," as properly computed on the resident's income tax return in the other state or foreign country, less all nonrefundable credits provided to the resident, and less any refundable credits provided to the resident for entity-level income taxes or composite income taxes paid by a pass-through entity. See Example 5 below.

e. Part-year Iowa residents. A taxpayer who is a part-year resident of Iowa may only claim the out-of-state tax credit against the taxpayer's Iowa income tax liability for income tax paid to another state or foreign country on income qualifying under paragraph 42.6(2) "a" that is earned during the period of the tax year that the taxpayer was an Iowa resident. The income tax paid to the other state or foreign country is the sum of the following amounts:

(1) Income tax treated as paid by the resident under subrules 42.6(3) and 42.6(4) on income earned during the period of the tax year that the taxpayer was an Iowa resident. The income tax shall be treated as paid by the resident for the tax year that the out-of-state pass-through income is considered taxable Iowa income.

(2) The net state or foreign income tax actually owed and paid by the taxpayer for the tax year on income qualifying under paragraph 42.6(2) "a" that was earned during the period of the tax year that the taxpayer was an Iowa resident, as properly computed on the resident's income tax return in the other state or foreign country, less all nonrefundable credits provided to the resident, and less any refundable credits provided to the resident for entity-level income taxes or composite income taxes paid by a pass-through entity. See Example 6 below.

42.6(6) *Computing the out-of-state tax credit—additional limitations and considerations.*

a. Maximum credit. The out-of-state tax credit cannot exceed the amount of Iowa income tax that would have been imposed on the same income which was taxed by the other state or foreign country. The maximum out-of-state tax credit must be computed according to the formula in this paragraph. If gross income is subject to tax in a jurisdiction at more than one level (i.e., at the pass-through entity level and at the individual level), it shall only be counted once for purposes of computing the maximum credit.

(1) Full-year Iowa residents. Gross income qualifying under paragraph 42.6(2) “a” and taxed by the other state or foreign country shall be divided by the total gross income of the Iowa resident taxpayer. This quotient, multiplied by the net Iowa tax as determined on the total gross income of the taxpayer as if entirely earned in Iowa, shall be the maximum tax credit. For tax years beginning before January 1, 2022, this quotient shall be computed as a percentage rounded to the nearest tenth of a percent (e.g., 1.2 percent). For tax years beginning on or after January 1, 2022, this quotient shall be computed as a percentage rounded to the nearest ten-thousandth of a percent (e.g., 1.2345 percent). For purposes of this subparagraph, “net Iowa tax” means the Iowa regular income tax after reduction for the nonrefundable credits provided in Iowa Code section 422.12.

EXAMPLE 5: Taxpayer A was an Iowa resident for the entire tax year but commuted across the border and worked in state Z. Taxpayer A had wages of \$30,000 in state Z. Taxpayer A filed an income tax return in state Z reporting the \$30,000 of wages and had state Z income tax liability of \$500, which is A’s preliminary out-of-state credit under subrule 42.6(5). Taxpayer A also had income of \$10,000 from rental of an Iowa farm and another \$10,000 in interest income from a personal savings account. Taxpayer A’s total gross income for the tax year was \$50,000. Thus, 60 percent ($\$30,000 \div \$50,000$) of Taxpayer A’s income was earned in state Z. Taxpayer A’s net Iowa tax on total gross income was \$817, which results in a maximum out-of-state credit of \$490 ($\$817 \times .60$). Therefore, the out-of-state tax credit allowed is \$490, because the maximum credit of \$490 was less than the preliminary credit of \$500.

(2) Part-year Iowa residents. Gross income qualifying under paragraph 42.6(2) “a” that was earned during the period of the tax year that the taxpayer was an Iowa resident and taxed by the other state or foreign country shall be divided by the total gross income of the Iowa taxpayer earned while an Iowa resident or otherwise sourced to Iowa. This quotient, multiplied by the net Iowa tax as determined on the total gross income of the taxpayer as if entirely earned in Iowa, shall be the maximum tax credit. For tax years beginning before January 1, 2022, this quotient shall be computed as a percentage rounded to the nearest tenth of a percent (e.g., 1.2 percent). For tax years beginning on or after January 1, 2022, this quotient shall be computed as a percentage rounded to the nearest ten-thousandth of a percent (e.g., 1.2345 percent). For purposes of this subparagraph, “net Iowa tax” means the Iowa regular income tax after reduction for the nonrefundable credits provided in Iowa Code section 422.12 and after reduction for the nonresident and part-year resident credit in rule 701—42.5(422).

EXAMPLE 6: Taxpayer B was a part-year Iowa resident for the tax year. Taxpayer B resided in state Z for the first six months of the year and moved to Iowa on July 1 but continued to commute across the border and work in state Z. Taxpayer B was employed in state Z for the entire year and had wages of \$30,000 in state Z. Taxpayer B filed an income tax return in state Z reporting the \$30,000 of wages and had state Z income tax liability of \$1,000. The amount of gross income taxed by state Z while taxpayer B was an Iowa resident was \$15,000 (50 percent of the \$30,000 of state Z wages). Since 50 percent of the income earned in state Z was earned while taxpayer B was a resident of Iowa, the preliminary out-of-state credit under subrule 42.6(5) was \$500 ($\$1,000 \times .50$). Taxpayer B also had \$10,000 in farm rental income from farmland located in Iowa. Taxpayer B’s gross income earned while an Iowa resident and otherwise sourced to Iowa was \$25,000 ($\$15,000$ of wages + $\$10,000$ farm rental income). Thus, 60 percent of the gross income was earned in state Z while an Iowa resident ($\$15,000 \div \$25,000$). Taxpayer B’s net Iowa tax on total gross income was \$1,094, which results in a maximum out-of-state credit of \$656 ($\$1,094 \times .60$). Therefore, the out-of-state tax credit allowed is \$500, because the preliminary credit of \$500 was less than the maximum credit of \$656.

b. Refund attributable to credit for entity-level income tax or composite income tax paid by a pass-through entity. If the resident claims a refundable tax credit in another state or foreign country for entity-level income tax or composite income tax paid by a pass-through entity, that refundable credit reduces the resident’s income tax liability in that state or foreign country as described in subparagraphs 42.6(5) “d”(2) and 42.6(5) “e”(2). However, any refund attributable to that refundable credit also reduces the amount of income tax treated as paid by the resident under subrules 42.6(3) and 42.6(4). In computing this credit reduction, the refundable credit for entity-level income tax or composite income tax paid by a pass-through entity shall be applied on the other state’s or foreign country’s income tax return after all

nonrefundable credits, but before any other refundable credit. The credit reduction is required whether the resident receives the refund or applies the amount to a different tax liability or tax period.

EXAMPLE 7: Individual B, a resident of Iowa and a 50 percent owner of Partnership P doing business in state Z, receives a statement from Partnership P in accordance with subparagraph 42.6(3)“a”(3) showing that P earned income in and paid entity-level income tax to state Z and individual B’s pro rata share of that income and that entity-level income tax is \$5,000 and \$250, respectively. However, individual B also receives a \$250 refundable credit from state Z for B’s share of the entity-level income tax paid by Partnership P. Individual B files an individual income tax return in state Z to report B’s pro rata share of income from Partnership P and calculates a tentative income tax of \$200, before application of the refundable credit. Individual B applies the refundable tax credit against that tentative income tax and calculates an income tax liability of \$0 and a refund of \$50 from state Z. Therefore, individual B must reduce the \$250 of entity-level income tax treated as paid by B under subrule 42.6(3) to \$200 (\$250 - \$50). Individual B files an Iowa income tax return which includes the \$5,000 of income from Partnership P earned in state Z and calculates a preliminary out-of-state tax credit under subrule 42.6(5) of \$200.

c. Taxpayers claiming the S corporation apportionment tax credit. A taxpayer who is a shareholder of an S corporation and who has income that was apportioned outside of Iowa through a claim to the S corporation apportionment tax credit is not permitted to claim the out-of-state tax credit on the same S corporation income. Income tax paid by the resident or a pass-through entity with respect to the S corporation income shall not be included in the resident’s preliminary credit calculation in paragraph 42.6(5)“d” or “e.” Gross income from the S corporation shall not be included in the resident’s maximum credit calculation in paragraph 42.6(6)“a.”

d. Married taxpayers using a different filing status in the other state or foreign country. If married taxpayers use a separate filing status in the other state or foreign country, but file jointly for Iowa tax purposes, the taxpayers must combine both spouses’ income and income tax paid in the other state or foreign country for purposes of computing the out-of-state tax credit. If married taxpayers file jointly in the other state or foreign country, but file separate Iowa returns, or separately on a combined Iowa return, the taxpayers must prorate the income tax paid in the other state or foreign country according to each spouse’s respective gross income earned in that state or foreign country.

e. Tax on income that does not flow through to resident. Entity-level income tax or composite income tax paid by a pass-through entity on income that does not flow through to the Iowa resident and meet the requirements of paragraph 42.6(2)“a” does not qualify for the out-of-state tax credit. For example, a LIFO recapture tax installment paid by an S corporation in another state would not qualify because that tax is measured by the income of the entity in the last tax year it was a C corporation, when such income did not flow through to the shareholders. Also, income tax paid by a trust in another state on income not distributed to the beneficiaries would not qualify because that income did not flow through to the beneficiaries. These examples are not intended to be exhaustive.

f. Recalculating credit following adjustments in the other jurisdiction. If the taxpayer or the taxpayer’s pass-through entity amends the amount of income or income tax liability reported and paid to the other state or foreign country, either through an amended return, audit, or otherwise, the taxpayer shall file an amended Iowa return and recalculate the allowable out-of-state tax credit. Any refund must be requested by the later of three years after the due date of the return, or one year after payment of the tax, as prescribed in Iowa Code section 422.73(2)“a.” Iowa law does not provide additional time to request a refund following an audit by another state or foreign country.

g. Nonrefundable and nontransferable. The out-of-state tax credit cannot exceed the resident’s tax liability; thus, no amount is eligible to be carried forward to any future tax year. The credit may not be transferred to any other person.

42.6(7) Claiming the out-of-state tax credit—supporting documentation. To claim the out-of-state tax credit, the taxpayer claiming the credit must submit the following to the department with the return or upon request as indicated below:

a. Out-of-state tax return. A copy of the income tax return filed with the other state or foreign country must be submitted. The department may further request a copy of the return which has been

certified by the tax authority of that state or foreign country and showing thereon that the income tax assessed has been paid to them.

b. Iowa income tax return. To claim the out-of-state tax credit, a taxpayer must file an Iowa income tax return for the tax year for which the credit is claimed. A taxpayer must file an Iowa income tax return to claim the out-of-state tax credit even if the taxpayer would not otherwise have an obligation to file an Iowa income tax return for the year for which the credit is claimed.

c. Iowa out-of-state tax credit schedule. An IA 130, Iowa Out-of-State Tax Credit Schedule, must be submitted for the tax year for which the credit is claimed.

d. Pass-through entity statements. A taxpayer who is claiming an out-of-state tax credit for entity-level income tax or composite income tax paid by a pass-through entity must submit a statement from the pass-through entity that meets the requirements of subrule 42.6(3). The pass-through entity's actual income tax returns must be submitted to the department upon request. A taxpayer who is claiming an out-of-state tax credit for entity-level income tax paid by a regulated investment company must submit a statement from the regulated investment company that meets the requirements of subrule 42.6(4).

e. Additional foreign income tax documentation. A taxpayer who is claiming the out-of-state tax credit for income taxes paid to a foreign country must provide the department with a copy of federal Form 1116, Foreign Tax Credit, if that form was required to be submitted with the taxpayer's federal income tax return. This submission requirement does not mean that all amounts on federal Form 1116 qualify for the Iowa out-of-state tax credit. Additionally, if the income tax was paid in foreign currency, the taxpayer shall include a detailed explanation of how the taxpayer figured the conversion rate. The conversion rate is the rate of exchange in effect on the day the taxpayer paid the foreign income tax.

f. Proof of payment. Upon request, the taxpayer must provide the department with a photocopy, or other similar reproduction, of either:

- (1) The receipt issued by the other state or foreign country for payment of the tax, or
- (2) The canceled check (both sides) with which the tax was paid to the other state or foreign country together with a statement of the amount and kind (e.g., wage or salary income, rental income, business income) of total income on which such tax was paid.

This rule is intended to implement Iowa Code section 422.8.
[ARC 6029C, IAB 11/3/21, effective 12/8/21]

701—42.7(422) Out-of-state tax credit for minimum tax.

42.7(1) General rule. Iowa residents are allowed an out-of-state tax credit for minimum taxes or income taxes paid to another state or foreign country on preference items derived from sources outside of Iowa. Part-year residents who pay minimum tax to another state or foreign country on preference items derived from sources outside Iowa will be allowed an out-of-state tax credit only to the extent that the minimum tax paid to the other state or foreign country relates to preference items that occurred during the period the taxpayer was an Iowa resident. Taxpayers who were nonresidents of Iowa for the entire tax year are not eligible for an out-of-state tax credit on their Iowa returns for minimum taxes paid to another state or foreign country on preference items.

If the Iowa resident is a partner, shareholder, member, or beneficiary of a partnership, S corporation, limited liability company, or trust which files a composite income tax return and pays minimum tax in another state on behalf of the partners, shareholders, members or beneficiaries, the out-of-state tax credit will be allowed for the Iowa resident. The Iowa resident must provide a schedule of the resident's share of the minimum tax paid to another state on a composite basis, and the out-of-state tax credit is limited based upon the calculation set forth in subrule 42.7(2).

However, if the partnership, S corporation, limited liability company, or trust is directly subject to minimum tax in another state and the minimum tax is not directly imposed on the resident taxpayer, then the out-of-state tax credit is not allowed for the Iowa resident on the minimum tax directly imposed on the partnership, S corporation, limited liability company, or trust. For example, if another state does not recognize the S corporation election for state tax purposes and a corporation income tax is imposed directly on the S corporation which includes minimum tax, then the out-of-state tax credit is not allowed

for the Iowa resident shareholder on the corporation income tax, including minimum tax, paid to the other state.

42.7(2) Limitation of out-of-state tax credit for minimum tax. The limitation on the out-of-state tax credit for minimum tax is that the credit shall not exceed the Iowa minimum tax that would have been computed on the same preference items which were taxed by the other state or foreign country. The limitation may be determined according to the following formula: The total of preference items earned outside of Iowa and taxed by another state or foreign country shall be divided by the total of preference items of the resident taxpayer. This quotient, multiplied by the state minimum tax on the total of preference items as if entirely earned in Iowa, shall be the maximum credit against the Iowa minimum tax. However, if the minimum tax imposed by the other state or foreign country is less than the minimum tax computed under the limitation formula, the out-of-state credit for minimum tax will not exceed the minimum tax imposed by the other state or foreign country.

No out-of-state credit will be allowed on the Iowa return for minimum tax paid to another state or foreign country to the extent that the minimum tax of the other state or foreign country is imposed on items of tax preference not subject to the Iowa minimum tax. In addition, no out-of-state credit will be allowed for minimum tax paid to another state or foreign country of capital gains or losses from distressed sales which are excluded from the Iowa minimum tax. Capital gains or losses from distressed sales are described in rule 701—40.27(422).

42.7(3) Proof of claim for out-of-state tax credit for minimum tax. The out-of-state credit for minimum tax may be claimed on the return of a taxpayer if proof of payment of minimum tax to the state or foreign country is included with the return. Documents needed for proof of payment are a photocopy of the minimum tax form of the state or country to which minimum tax was paid as well as instructions from the minimum tax form or other information which specifies how the minimum tax is imposed and what preference items are subject to the minimum tax of that state or foreign country.

In the case of audit by the department of a taxpayer claiming an out-of-state tax credit for minimum tax paid, the department may require additional proof of payment of the out-of-state tax credit. The department will accept any of the following documents as verification of payment of the minimum tax:

- a. A photocopy, or other similar reproduction, of either:
 - (1) The receipt issued by the other state or foreign country for payment of the tax, including the minimum tax, or
 - (2) The canceled check (both sides) which was used for payment of the minimum tax to the other state or foreign country.
- b. A copy of the return filed with the other state or foreign country which has been certified by the tax authority of that state or foreign country and which shows that the income tax, including the minimum tax, has been paid.

This rule is intended to implement Iowa Code section 422.8.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.8(422) Withholding and estimated tax credits. An employee from whose wages tax is withheld shall claim credit for the tax withheld on the employee's income tax return for the year during which the tax was withheld. Credit will be allowed only if a copy of the withholding statement is attached to the return. Taxpayers who have made estimated income tax payments shall claim credit for the estimated tax paid for the taxable year.

This rule is intended to implement Iowa Code section 422.16.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.9(422) Motor fuel credit. An individual, partnership, limited liability company, or S corporation may elect to receive an income tax credit in lieu of the motor fuel tax refund provided by Iowa Code chapter 452A. An individual, partnership, limited liability company, or S corporation which holds a motor fuel tax refund permit under Iowa Code section 452A.18 when it makes this election must cancel the permit within 30 days after the first day of the tax year. However, if the refund permit is not canceled within this period, the permit becomes invalid at the time the election to receive an

income tax credit is made. The election will continue for subsequent tax years unless a new motor fuel tax refund permit is obtained.

The motor fuel income tax credit must be the amount of Iowa motor fuel tax paid on qualifying fuel purchases as determined by Iowa Code chapter 452A and Iowa Code section 422.110 less any state sales tax as determined by 701—subrule 231.2(2). The credit must be claimed on the tax return covering the tax year in which the motor fuel tax was paid. If the motor fuel credit results in an overpayment of income tax, the overpayment may be refunded or may be credited to income tax due in the subsequent tax year.

The motor fuel tax credits for fuel taxes paid by partnerships, limited liability companies, and S corporations are not claimed on returns filed for the partnerships, limited liability companies, and S corporations. Instead, the pro rata shares of the motor fuel tax credits are allocated to the partners, members, and shareholders in the same ratio as incomes are allocated to the partners, members, and shareholders. A schedule must be attached to the individual's returns showing the distribution of gallons and the amount of credit claimed by each partner, member, or shareholder.

The partnership, limited liability company, or S corporation must attach to its return a schedule showing the allocation to each partner, member, or shareholder of the motor fuel purchased by the partnership, limited liability company, or S corporation which qualifies for the credit.

This rule is intended to implement Iowa Code sections 422.110 and 422.111.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.10(422) Alternative minimum tax credit for minimum tax paid in a prior tax year. Minimum tax paid in prior tax years commencing with tax years beginning on or after January 1, 1987, by a taxpayer can be claimed as a tax credit against the taxpayer's regular income tax liability in a subsequent tax year. Therefore, 1988 is the first tax year that the minimum tax credit is available, and the credit is based on the minimum tax paid by the taxpayer for 1987. The minimum tax credit may only be used against regular income tax for a tax year to the extent that the regular tax is greater than the minimum tax for the tax year. If the minimum tax credit is not used against the regular tax for a tax year, the remaining credit is carried over to the following tax year to be applied against the regular income tax liability for that period. The minimum tax credit is computed on Form IA 8801.

42.10(1) Examples of computation of the minimum tax credit and carryover of the credit.

EXAMPLE 1. The taxpayers reported \$5,000 of minimum tax for 2007. For 2008, the taxpayers reported regular tax of \$8,000, and the minimum tax liability is \$6,000. The minimum tax credit is \$2,000 for 2008 because, although the taxpayers had an \$8,000 regular tax liability, the credit is allowed only to the extent that the regular tax exceeds the minimum tax. Since only \$2,000 of the carryover credit from 2007 was used, there is a \$3,000 minimum tax carryover credit to 2009.

EXAMPLE 2. The taxpayers reported \$2,500 of minimum tax for 2007. For 2008, the taxpayers reported regular tax of \$8,000, and the minimum tax liability is \$5,000. The minimum tax credit is \$2,500 for 2008 because, although the regular tax exceeded the minimum tax by \$3,000, the credit is allowed only to the extent of minimum tax paid for prior tax years. There is no minimum tax carryover credit to 2009.

42.10(2) Minimum tax credit for nonresidents and part-year residents. Nonresident and part-year resident taxpayers who paid Iowa minimum tax in tax years beginning on or after January 1, 1987, are eligible for the minimum tax credit to the extent that the minimum tax they paid was attributable to tax preferences and adjustments. Therefore, if a nonresident or part-year resident taxpayer had Iowa source tax preferences or adjustments, then all the minimum tax that was paid would qualify for the minimum tax credit.

The minimum tax credit for a tax year as computed above applies to the regular income tax liability less the nonresident part-year credit to the extent this regular tax amount exceeds the minimum tax for the tax year. To the extent the credit is not used, the credit can be carried over to the next tax year.

This rule is intended to implement Iowa Code section 422.11B.
[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 2829C, IAB 11/23/16, effective 1/1/17]

701—42.11(15,422) Research activities credit. The taxes imposed on individual income shall be reduced by a state tax credit for increasing research activities in this state. For individual income tax, the requirements of the research activities credit are described in Iowa Code section 422.10. This rule explains terms not defined in the statute and procedures for claiming the credit.

42.11(1) Definitions.

“*Accountant*” means a person authorized under Iowa Code chapter 542 to engage in the practice of public accounting in Iowa as defined in Iowa Code section 542.3(23) or authorized to engage in such practice in another state under a similar law of another state.

“*Architect*” means a person licensed under Iowa Code chapter 544A or a similar law of another state.

“*Aviation and aerospace*” means the design, development or production of aircraft, rockets, missiles, spacecraft and other machinery and equipment that operate in aerospace.

“*Collection agency*” means a person primarily engaged in the business of collecting debt, including but not limited to consumer debt collection subject to the provisions of the federal Fair Debt Collections Practices Act in 15 U.S.C. §1692 et seq., the Iowa debt collection practices Act in Iowa Code sections 537.7101 through 537.7103, or other similar state law.

“*Finance or investment company*” means a person primarily engaged in finance or investment activities broadly consisting of the holding, depositing, or management of a customer’s money or assets for investment purposes, or the provision of loans or other similar financing or credit to customers. “Finance or investment company” includes but is not limited to a person organized or licensed under Iowa Code chapter 524, 533, or 533D or other similar state or federal law, or an investment company as defined in 15 U.S.C. §80a-3.

“*Life sciences*” means the sciences concerned with the study of living organisms, including agriscience, biology, botany, zoology, microbiology, physiology, biochemistry, and related subjects.

“*Manufacturing*” means the same as defined in 2018 Iowa Acts, Senate File 2417, section 183.

“*Publisher*” means a person whose primary business is the publishing of books, periodicals, newspapers, music, or other works for sale in any format.

“*Real estate company*” means a person licensed under Iowa Code chapter 543B or otherwise primarily engaged in acts constituting dealing in real estate as described in Iowa Code section 543B.6.

“*Retailer*” means a person that primarily engages in sales of personal property as defined in 2018 Iowa Acts, Senate File 2417, section 158, or services directly to an ultimate consumer. A business that primarily makes sales for resale is not a retailer.

“*Software engineering*” means the detailed study of the design, development, operation, and maintenance of software.

“*Transportation company*” means a person whose primary business is the transportation of persons or property from one place to another.

“*Wholesaler*” means a person that primarily engages in buying large quantities of goods and reselling them in smaller quantities to retailers or other merchants who in turn sell those goods to the ultimate consumer.

42.11(2) Requirement that the business claim and be allowed the federal credit. To claim this credit, a taxpayer’s business must claim and be allowed a research credit for such qualified research expenses under Section 41 of the Internal Revenue Code for the same taxable year as the taxpayer’s business is claiming the credit.

a. Being “allowed” the federal credit. For purposes of this subrule, a federal credit is “allowed” if the taxpayer meets all requirements to claim the credit under Section 41 of the Internal Revenue Code and any applicable federal regulation and Internal Revenue Service guidance and such credit has not been disallowed by the Internal Revenue Service.

b. Applicability of requirement to pass-throughs. If the individual received the Iowa credit through a pass-through entity, the pass-through entity that conducted the research must have claimed and been allowed the federal credit in order for the individual to claim the Iowa credit.

c. Impact of federal audit. If the Internal Revenue Service audits or otherwise reviews the return and disallows the credit, the taxpayer shall file an amended Iowa return along with supporting schedules, including an amended federal return or a copy of the federal revenue agent’s report and notification of

final federal adjustments, to add back the Iowa credit to the extent not previously disallowed by the department.

d. Authority of the department. Nothing in this subrule shall limit the department's authority to review, examine, audit, or otherwise challenge an Iowa tax credit claim under Iowa Code section 422.10, regardless of inaction, a settlement, or a determination by the Internal Revenue Service under Section 41 of the Internal Revenue Code.

42.11(3) Calculating the credit. For information on how the credit is calculated, see Iowa Code section 422.10.

42.11(4) Claiming the tax credit.

a. Forms. The credit must be claimed on the forms provided on the department's website and must include all information required by the forms.

b. Allocation to the individual owners of an entity or beneficiaries of an estate or trust. An individual may claim a research activities credit incurred by a partnership, S corporation, limited liability company, estate, or trust electing to have the income of the business entity taxed to the individual. The amount claimed by an individual from the business entity shall be based upon the pro rata share of the individual's earnings from a partnership, S corporation, estate or trust.

c. Refundability. Any research credit in excess of the individual's tax liability, less the nonrefundable credits authorized in Iowa Code chapter 422, division II, may be refunded to the individual or may be credited to the individual's tax liability for the following tax year.

d. Transferability. Tax credit certificates shall not be transferred to any other person.

e. Enterprise zone claimants. The enterprise zone program was repealed on July 1, 2014. However, any supplemental research activities credit earned by businesses pursuant to Iowa Code section 15.335 and approved under the enterprise zone program prior to July 1, 2014, remains valid and can be claimed on tax returns filed after July 1, 2014.

This rule is intended to implement Iowa Code sections 15.335 and 422.10 as amended by 2018 Iowa Acts, Senate File 2417.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 9820B, IAB 11/2/11, effective 12/7/11; ARC 0337C, IAB 9/19/12, effective 10/24/12; ARC 1101C, IAB 10/16/13, effective 11/20/13; ARC 1545C, IAB 7/23/14, effective 8/27/14; ARC 1744C, IAB 11/26/14, effective 12/31/14; ARC 4143C, IAB 11/21/18, effective 12/26/18]

701—42.12(422) New jobs credit. A tax credit is available to an individual who has entered into an agreement under Iowa Code chapter 260E and has increased employment by at least 10 percent.

42.12(1) Definitions.

a. The term "new jobs" means those jobs directly resulting from a project covered by an agreement authorized by Iowa Code chapter 260E (Iowa industrial new jobs training Act) but does not include jobs of recalled workers or replacement jobs or other jobs that formerly existed in the industry in this state.

b. The term "jobs directly related to new jobs" means those jobs which directly support the new jobs but do not include in-state employees transferred to a position which would be considered to be a job directly related to new jobs unless the transferred employee's vacant position is filled by a new employee. The burden of proof that a job is directly related to new jobs is on the taxpayer.

EXAMPLE A. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line, transfers an in-state employee to be foreman of the new product line but does not fill the transferred employee's position. The new foreman's position would not be considered a job directly related to new jobs even though it directly supports the new jobs because the transferred employee's old position was not refilled.

EXAMPLE B. A taxpayer who has entered into a chapter 260E agreement to train new employees for a new product line transfers an in-state employee to be foreman of the new product line and fills the transferred employee's position with a new employee. The new foreman's position would be considered a job directly related to new jobs because it directly supports the new jobs and the transferred employee's old position was filled by a new employee.

c. The term "taxable wages" means those wages upon which an employer is required to contribute to the state unemployment fund as defined in Iowa Code subsection 96.19(37) for the year in which the taxpayer elects to take the new jobs tax credit. For fiscal year taxpayers, "taxable wages" shall

not be greater than the maximum wage upon which an employer is required to contribute to the state unemployment fund for the calendar year in which the taxpayer's fiscal year begins.

d. The term "agreement" means an agreement entered into under Iowa Code chapter 260E after July 1, 1985, an amendment to that agreement, or an amendment to an agreement entered into before July 1, 1985, if the amendment sets forth the base employment level as of the date of the amendment. The term "agreement" also includes a preliminary agreement entered into under Iowa Code chapter 260E provided the preliminary agreement contains all the elements of a contract and includes the necessary elements and commitments relating to training programs and new jobs.

e. The term "base employment level" means the number of full-time jobs an industry employs at a plant site which is covered by an agreement under Iowa Code chapter 260E on the date of the agreement.

f. The term "project" means a training arrangement which is the subject of an agreement entered into under Iowa Code chapter 260E.

g. The term "industry" means a business engaged in interstate or intrastate commerce for the purpose of manufacturing, processing, or assembling products, conducting research and development, or providing services in interstate commerce, but excludes retail, health, and professional services. "Industry" does not include a business which closes or substantially reduces its operations in one area of the state and relocates substantially the same operation in another area of the state. "Industry" is a business engaged in the above-listed activities rather than the generic definition encompassing all businesses in the state engaged in the same activities. For example, in the meat-packing business, an industry is considered to be a single corporate entity or operating division, rather than the entire meat-packing business in the state.

h. The term "new employees" means the same as new jobs or jobs directly related to new jobs.

i. The term "full-time job" means any of the following:

- (1) An employment position requiring an average work week of 35 or more hours;
- (2) An employment position for which compensation is paid on a salaried full-time basis without regard to hours worked; or
- (3) An aggregation of any number of part-time or job-sharing employment positions which equal one full-time employment position. For purposes of this subrule, each part-time or job-sharing employment position shall be categorized with regard to the average number of hours worked each week as one-quarter, half, three-quarters, or full-time position, as set forth in the following table:

Average Number of Weekly Hours	Category
More than 0 but less than 15	¼
15 or more but less than 25	½
25 or more but less than 35	¾
35 or more	1 (full-time)

42.12(2) How to compute the credit. The credit is 6 percent of the taxable wages paid to employees in new jobs or jobs directly related to new jobs for the taxable year in which the taxpayer elects to take the credit.

EXAMPLE 1. A taxpayer enters into an agreement to increase employment by 20 new employees which is greater than 10 percent of the taxpayer's base employment level of 100 employees. In year one of the agreement, the taxpayer hires 20 new employees but elects not to take the credit in that year. In year two of the agreement, only 18 of the new employees hired in year one are still employed and the taxpayer elects to take the credit. The credit would be 6 percent of the taxable wages of the 18 remaining new employees. In year three of the agreement, the taxpayer hires two additional new employees under the agreement to replace the two employees that left in year two and elects to take the credit. The credit would be 6 percent of the taxable wages paid to the two replacement employees. In year four of the agreement, three of the employees for which a credit had been taken left employment and three additional employees were hired. No credit is available for these employees. A credit can only be taken one time for each new job or job directly related to a new job.

EXAMPLE 2. A taxpayer operating two plants in Iowa enters into a chapter 260E agreement to train new employees for a new product line at one of the taxpayer's plants. The base employment level on the date of the agreement at plant A is 300 and at plant B is 100. Under the agreement, 20 new employees will be trained for plant B which is greater than a 10 percent increase of the base employment level for plant B. In the year in which the taxpayer elects to take the credit, the employment level at plant A is 290 and at plant B is 120. The credit would be 6 percent of the wages of 10 new employees at plant B as 10 new jobs were created by the industry in the state. A credit for the remaining 10 employees can be taken if the employment level at plant A increases back to 300 during the period of time that the credit can be taken.

42.12(3) *When the credit can be taken.* The taxpayer may elect to take the credit in any tax year which either begins or ends during the period beginning with the date of the agreement and ending with the date by which the project is to be completed under the agreement. However, the taxpayer may not take the credit until the base employment level has been exceeded by at least 10 percent.

EXAMPLE: A taxpayer enters into an agreement to increase employment from a base employment level of 200 employees to 225 employees. In year one of the agreement, the taxpayer hires 20 new employees which is a 10 percent increase over the base employment level but elects not to take the credit. In year two of the agreement, two of the new employees leave employment. The taxpayer elects to take the credit which would be 6 percent of the taxable wages of the 18 employees currently employed. In year three, the taxpayer hires 7 new employees and elects to take the credit. The credit would be 6 percent of the taxable wages of the 7 new employees.

A taxpayer may claim on the taxpayer's individual income tax return the pro rata share of the Iowa new jobs credit from a partnership, subchapter S corporation, estate or trust. The portion of the credit claimed by the individual shall be in the same ratio as the individual's pro rata share of the earnings of the partnership, subchapter S corporation, or estate or trust. All partners in a partnership, shareholders in a subchapter S corporation and beneficiaries in an estate or trust shall elect to take the Iowa new jobs credit the same year.

For tax years beginning prior to January 1, 2007, any Iowa new jobs credit in excess of the individual's tax liability less the credits authorized in Iowa Code sections 422.12 and 422.12B may be carried forward for ten years or until it is used, whichever is the earlier. For tax years beginning on or after January 1, 2007, any Iowa new jobs credit in excess of the individual's tax liability less the credits authorized in Iowa Code section 422.12 may be carried forward for ten years or until it is used, whichever is the earlier.

This rule is intended to implement Iowa Code section 422.11A.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.13(422) Earned income credit.

42.13(1) *Tax years beginning before January 1, 2007.* Effective for tax years beginning on or after January 1, 1990, an individual is allowed an Iowa earned income credit equal to a percentage of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. The Iowa earned income credit is nonrefundable; therefore, the credit may not exceed the remaining income tax liability of the taxpayer after the personal exemption credits and the other nonrefundable credits are deducted. The percentage of the earned income credit for tax years beginning in the 1990 calendar year is 5 percent. The percentage of the earned income credit for tax years beginning on or after January 1, 1991, is 6.5 percent.

For federal income tax purposes, the earned income credit is available for a low-income worker who maintains a household in the United States that is the principal place of abode of the worker and a child or children for more than one-half of the tax year or the worker must have provided a home for the entire tax year for a dependent parent. In addition, the worker must be (1) a married person who files a joint return and is entitled to a dependency exemption for a son or daughter, adopted child or stepchild; (2) a surviving spouse; or (3) an individual who qualifies as a head of household as described in Section 2(b) of the Internal Revenue Code. The federal earned income credit for a taxpayer is determined by computing the taxpayer's earned income on a worksheet provided in the federal income tax return instructions and

determining the allowable credit from a table included in the instructions for the 1040 or 1040A. For purposes of the credit, a taxpayer's earned income includes wages, salaries, tips, or other compensation plus net income from self-employment.

In the case of married taxpayers who filed a joint federal return and who elected to file separate state returns or separately on the combined return form, the Iowa earned income credit is allocated between the spouses in the ratio that each spouse's earned income relates to the earned income of both spouses.

Nonresidents and part-year residents of Iowa are allowed the same earned income credits as resident taxpayers.

42.13(2) *Tax years beginning on or after January 1, 2007.* Effective for tax years beginning on or after January 1, 2007, but beginning before January 1, 2013, an individual is allowed an Iowa earned income credit equal to 7 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. For tax years beginning on or after January 1, 2013, but beginning before January 1, 2014, an individual is allowed an Iowa earned income tax credit equal to 14 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. For tax years beginning on or after January 1, 2014, an individual is allowed an Iowa earned income tax credit equal to 15 percent of the earned income credit to which the taxpayer is entitled on the taxpayer's federal income tax return as authorized in Section 32 of the Internal Revenue Code. The Iowa earned income credit is refundable; therefore, the credit may exceed the remaining income tax liability of the taxpayer after the personal exemption credits and other nonrefundable credits are deducted.

In the case of married taxpayers who filed a joint federal return and who elected to file separate state returns or separately on the combined return form, the Iowa earned income credit is allocated between the spouses in the ratio that each spouse's earned income relates to the earned income of both spouses.

Nonresidents or part-year residents of Iowa must determine the Iowa earned income tax credit in the ratio of their Iowa source net income to their total source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or separately on the combined return form, the Iowa earned income credit must be allocated between the spouses in the ratio of each spouse's Iowa source net income to the combined Iowa source net income.

EXAMPLE: A married couple lives in Omaha, Nebraska. One spouse worked in Iowa in 2007 and had wages and other income from Iowa sources of \$12,000. That spouse had a federal adjusted gross income from all sources of \$15,000. The other spouse had no Iowa source net income and had a federal adjusted gross income from all sources of \$10,000. The taxpayers had a federal earned income credit of \$2,800.

The federal earned income credit of \$2,800 multiplied by 7 percent equals \$196. The ratio of Iowa source net income of \$12,000 divided by total source net income of \$25,000 equals 48 percent. The Iowa earned income tax credit equals \$196 multiplied by 48 percent, or \$94.

This rule is intended to implement Iowa Code section 422.12B as amended by 2013 Iowa Acts, Senate File 295.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1102C, IAB 10/16/13, effective 11/20/13]

701—42.14(15) Investment tax credit—new jobs and income program and enterprise zone program.

42.14(1) *General rule.* An investment tax credit of up to 10 percent of the new investment which is directly related to new jobs created by the location or expansion of an eligible business is available for businesses approved by the economic development authority under the new jobs and income program and the enterprise zone program. The new jobs and income program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—42.29(15) for information on the investment tax credit under the high quality job creation program. Any investment tax credit earned by businesses approved under the new jobs and income program prior to July 1, 2005, remains valid and can be claimed on tax returns filed after July 1, 2005. The credit is available for machinery and equipment or improvements to real property placed in service after May 1, 1994. The credit shall be taken

in the year the qualifying asset is placed in service. The enterprise zone program was repealed on July 1, 2014. Any investment tax credit earned by businesses approved under the enterprise zone program prior to July 1, 2014, remains valid and can be claimed on tax returns filed after July 1, 2014. For business applications received by the economic development authority on or after July 1, 1999, purchases of real property made in conjunction with the location or expansion of an eligible business, the cost of land and any buildings and structures located on the land will be considered to be new investment which is directly related to new jobs for purposes of determining the amount of new investment upon which an investment tax credit may be taken. For projects approved on or after July 1, 2005, under the enterprise zone program, the investment tax credit will be amortized over a five-year period, as described in subrule 42.29(2).

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of ten years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax year may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by the individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.14(2) Investment tax credit—value-added agricultural products or biotechnology-related processes. For tax years beginning on or after July 1, 2001, an eligible business whose project primarily involves the production of value-added agricultural products may elect to receive a refund for all or a portion of an unused investment tax credit. For tax years beginning on or after July 1, 2001, but before July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol. For tax years beginning on or after July 1, 2003, an eligible business includes a cooperative described in Section 521 of the Internal Revenue Code which is not required to file an Iowa corporation income tax return. For tax years ending on or after July 1, 2005, an eligible business approved under the enterprise zone program whose project primarily involves biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit.

Eligible businesses shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development will not issue tax credit certificates for more than \$4 million during a fiscal year for this program and eligible businesses described in subrule 42.29(2). If applications are received for more than \$4 million, the applicants shall receive certificates for a prorated amount.

The economic development authority will issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol for tax years beginning on or after January 1, 2002,

or for a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return for tax years beginning on or after July 1, 2003.

For value-added agricultural projects, for a cooperative that is not required to file an Iowa income tax return because it is exempt from federal income tax, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The Iowa department of economic development will issue a tax credit certificate to each member on the list.

See 701—subrule 52.10(4) for examples illustrating how this subrule is applied.

For tax years beginning on or after January 1, 2002, but before July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return and whose project primarily involves the production of ethanol may elect to transfer all or a portion of its tax credit to its members. For tax years beginning on or after July 1, 2003, a cooperative described in Section 521 of the Internal Revenue Code which is required to file an Iowa corporation income tax return may elect to transfer all or a portion of its tax credit to its members. The amount of tax credit transferred and claimed by a member shall be based upon the pro rata share of the member's earnings in the cooperative. The economic development authority will issue a tax credit certificate to each member of the cooperative to whom the credit was transferred provided that tax credit certificates which total no more than \$4 million are issued during a fiscal year. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed.

42.14(3) *Repayment of credits.* If an eligible business fails to maintain the requirements of the new jobs and income program or the enterprise zone program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new jobs and income program or the enterprise zone program because this repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.*, Docket No. 11DORF 042-044, June 11, 2012.

If the eligible business, within five years of purchase, sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this rule, the income tax liability of the eligible business for the year in which all or part of the property is sold, disposed of, razed, or otherwise rendered unusable shall be increased by one of the following amounts:

- a.* One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.
- b.* Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.
- c.* Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.
- d.* Forty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.
- e.* Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

This rule is intended to implement Iowa Code section 15.333 as amended by 2010 Iowa Acts, Senate File 2380.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.15(422) Child and dependent care credit. There is a child and dependent care credit which is refundable to the extent the amount of the credit exceeds the taxpayer's income tax liability less other applicable income tax credits. If a taxpayer claims the child and dependent care credit, the taxpayer cannot claim the early childhood development credit described in rule 701—42.31(422).

42.15(1) Computation of the Iowa child and dependent care credit. The Iowa child and dependent care credit is computed as a percentage of the child and dependent care credit which is allowed for federal income tax purposes under Section 21 of the Internal Revenue Code. For tax years beginning on or after January 1, 2015, the Iowa credit is computed without regard to whether or not the federal credit was limited to the taxpayer's federal tax liability. In addition, for tax years beginning on or after January 1, 2015, the Iowa credit will be allowed even if the taxpayer's federal adjusted gross income is below \$0. The credit is computed so that taxpayers with lower net incomes are allowed higher percentages of their federal child care credit than taxpayers with higher net incomes. The following is a schedule showing the percentages of federal child and dependent care credits allowed on the taxpayers' Iowa returns on the basis of the net incomes of the taxpayers.

* Net income	Percentage of federal credit allowed for tax years beginning on or after January 1, 2006, and before January 1, 2021	Percentage of federal credit allowed for tax years beginning on or after January 1, 2021
Less than \$10,000	75%	75%
\$10,000 or more but less than \$20,000	65%	65%
\$20,000 or more but less than \$25,000	55%	55%
\$25,000 or more but less than \$35,000	50%	50%
\$35,000 or more but less than \$40,000	40%	40%
\$40,000 or more but less than \$45,000	30%	30%
\$45,000 or more but less than \$90,000	No Credit	30%
\$90,000 or more	No Credit	No Credit

*Note that in the case of married taxpayers who have filed joint federal returns and elect to file separate returns or to file separately on the combined return form for Iowa purposes, the taxpayers must determine the child and dependent care credit by the schedule provided in this rule on the basis of their combined net incomes. The credit determined from the schedule must be allocated between the married taxpayers in the proportion that each spouse's net income relates to the combined net income of the taxpayers.

42.15(2) Examples of computation of the Iowa child and dependent care credit. The following are examples of computation of the child and dependent care credit and the allocation of the credit between spouses in situations where married taxpayers have filed joint federal returns and are filing separate Iowa returns or are filing separately on the combined Iowa return form.

EXAMPLE A: A married couple has a combined net income of \$40,000. Both spouses were employed. They had a federal child and dependent care credit of \$600 which related to expenses incurred for care of their two small children. One of the spouses had a net income of \$30,000 and the second spouse had a net income of \$10,000.

The taxpayers' Iowa child and dependent care credit was \$180 since they were entitled to an Iowa child and dependent care credit of 30 percent of their federal credit of \$600. If the taxpayers elect to file separate Iowa returns, the \$180 credit would be allocated between the spouses on the basis of each spouse's net income as it relates to the combined net income of both spouses as shown below:

$$\begin{aligned} \$180 \times \frac{\$30,000}{\$40,000} &= \$135 \quad \text{child and dependent care credit for spouse} \\ &\quad \text{with \$30,000 net income} \\ \\ \$180 \times \frac{\$10,000}{\$40,000} &= \$45 \quad \text{child and dependent care credit for spouse} \\ &\quad \text{with \$10,000 net income} \end{aligned}$$

EXAMPLE B: A married couple filed their Iowa return separately on a combined return. Both spouses were employed. They had a federal child and dependent care credit of \$800 which related to expenses incurred for care of their children. One spouse had a net income of \$25,000 and the other spouse had a net income of \$12,500, so their combined net income was \$37,500.

The taxpayers' Iowa child and dependent care credit was \$320, since they were entitled to an Iowa credit of 40 percent of their federal credit of \$800. The \$320 credit is allocated between the spouses on the basis of each spouse's Iowa net income as it relates to the combined Iowa net income of both spouses as shown below:

$$\begin{aligned} \$320 \times \frac{\$25,000}{\$37,500} &= \$213 \quad \text{child and dependent care credit for spouse} \\ &\quad \text{with \$25,000 Iowa net income} \\ \\ \$320 \times \frac{\$12,500}{\$37,500} &= \$107 \quad \text{child and dependent care credit for spouse} \\ &\quad \text{with \$12,500 Iowa net income} \end{aligned}$$

42.15(3) Computation of the Iowa child and dependent care credit for nonresidents and part-year residents. Nonresidents and part-year residents who have income from Iowa sources in the tax year may claim child and dependent care credits on their Iowa returns. The percentage of the federal credit allowed is determined based on the nonresident or part-year resident's all-source net income. If the nonresident or part-year resident's all-source net income is \$90,000 or higher, the taxpayer will not qualify for the Iowa child and dependent care credit regardless of the amount of the taxpayer's Iowa-source income. To compute the amount of child and dependent care credit that can be claimed on the Iowa return by a nonresident or part-year resident, the following formula shall be used:

Federal child and dependent care credit	×	Percentage of federal child and dependent credit allowed on Iowa return from table in subrule 42.15(1) based on all-source net income	×	<u>*Iowa net income</u> All-source net income
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*Iowa net income for purposes of determining the child care credit that can be claimed on the Iowa return by a nonresident or part-year resident taxpayer is the total Iowa-source income less the Iowa-source adjustments to income as computed on the Schedule IA 126.

In cases where married taxpayers are nonresidents or part-year residents of Iowa and are filing separate Iowa returns or are filing separately on the combined Iowa return form, the child and dependent care credit allowable on the Iowa return should be allocated between the spouses in the ratio of the Iowa net income of each spouse to the combined Iowa net income of the taxpayers.

42.15(4) Example of computation of the Iowa child and dependent care credit for nonresidents and part-year residents. The following is an example of the computation of the Iowa child and dependent care credit for nonresidents and part-year residents.

A married couple lives in Omaha, Nebraska. One of the spouses worked in Iowa and had an Iowa-source net income of \$15,000. That spouse had an all-source net income of \$20,000. The second spouse had an Iowa-source net income of \$10,000 and an all-source net income of \$15,000. The

couple had a combined Iowa-source net income of \$25,000 and a combined all-source net income of \$35,000. The taxpayers had a federal child and dependent care credit of \$800 which related to expenses incurred for the care of their two young children. The taxpayers' Iowa child and dependent care credit is calculated below:

Federal child and dependent care credit	Percentage of federal child and dependent credit allowed on Iowa return	Iowa-source net income	All-source net income
\$800	× 40% =	\$320	× $\frac{\$25,000}{\$35,000}$ = \$229

The \$229 credit is allocated between the spouses as shown below:

\$229 ×	$\frac{\$15,000}{\$25,000}$ =	\$137 for spouse with Iowa-source net income of \$15,000
\$229 ×	$\frac{\$10,000}{\$25,000}$ =	\$92 for spouse with Iowa-source net income of \$10,000

This rule is intended to implement Iowa Code section 422.12C.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 0337C, IAB 9/19/12, effective 10/24/12; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 6149C, IAB 1/12/22, effective 2/16/22]

701—42.16(422) Franchise tax credit. For tax years beginning on or after January 1, 1997, a shareholder in a financial institution, as defined in Section 581 of the Internal Revenue Code, which has elected to have its income taxed directly to the shareholders may take a tax credit equal to the shareholder's pro rata share of the Iowa franchise tax paid by the financial institution.

For tax years beginning on or after July 1, 2004, a member of a financial institution organized as a limited liability company that is taxed as a partnership for federal income tax purposes which has elected to have its income taxed directly to its members may take a tax credit equal to the member's pro rata share of the Iowa franchise tax paid by the financial institution.

The credit must be computed by recomputing the amount of tax computed under Iowa Code section 422.5 by reducing the shareholder's or member's taxable income by the shareholder's or member's pro rata share of the items of income and expenses of the financial institution and subtracting the credits allowed in Iowa Code sections 422.12 and 422.12B for tax years beginning prior to January 1, 2007. The recomputed tax must be subtracted from the amount of tax computed under Iowa Code section 422.5 reduced by the credits allowed in Iowa Code sections 422.12 and 422.12B for tax years beginning prior to January 1, 2007. For tax years beginning on or after January 1, 2007, only the credits allowed in Iowa Code section 422.12 are reduced in computing the franchise tax credit.

The resulting amount, not to exceed the shareholder's or member's pro rata share of the franchise tax paid by the financial institution, is the amount of tax credit allowed the shareholder or member.

This rule is intended to implement Iowa Code section 422.11.

[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.17(15E) Eligible housing business tax credit. An individual who qualifies as an eligible housing business may receive a tax credit of up to 10 percent of the new investment which is directly related to the building or rehabilitating of homes in an enterprise zone. The enterprise zone program was repealed on July 1, 2014, and the eligible housing business tax credit has been replaced with the workforce housing tax incentives program. See rule 701—42.53(15) for information on the tax incentives provided under the workforce housing tax incentives program. Any investment tax credit

earned by businesses approved under the enterprise zone program prior to July 1, 2014, remains valid and can be claimed on tax returns filed after July 1, 2014. The tax credit may be taken on the tax return for the tax year in which the home is ready for occupancy.

An eligible housing business is one which meets the criteria in 2014 Iowa Code section 15E.193B.

42.17(1) Computation of credit. New investment which is directly related to the building or rehabilitating of homes includes but is not limited to the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing, plumbing materials, electrical materials, amounts paid to subcontractors for labor and materials provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

New investment does not include the machinery, equipment, or hand or power tools necessary to build or rehabilitate homes.

A taxpayer may claim on the taxpayer's individual income tax return the pro rata share of the Iowa eligible housing business tax credit from a partnership, S corporation, limited liability company, estate, or trust. The portion of the credit claimed by the individual shall be in the same ratio as the individual's pro rata share of the earnings of the partnership, S corporation, limited liability company, or estate or trust, except for projects beginning on or after July 1, 2005, which used low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. For these projects, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder.

For tax years beginning prior to January 1, 2007, any Iowa eligible housing business tax credit in excess of the individual's tax liability, less the credits authorized in Iowa Code sections 422.12 and 422.12B, may be carried forward for seven years or until it is used, whichever is the earlier. For tax years beginning on or after January 1, 2007, any Iowa eligible housing business tax credit in excess of the individual's tax liability less the credits authorized in Iowa Code section 422.12 may be carried forward for seven years or until it is used, whichever is the earlier.

If the eligible housing business fails to maintain the requirements of 2014 Iowa Code section 15E.193B, the taxpayer, in order to be an eligible housing business, may be required to repay all or a part of the tax incentives the taxpayer received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of 2014 Iowa Code section 15E.193B. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.*, Docket No. 11DORF 042-044, June 11, 2012.

Prior to January 1, 2001, the tax credit cannot exceed 10 percent of \$120,000 for each home or individual unit in a multiple dwelling unit building. Effective January 1, 2001, the tax credit cannot exceed 10 percent of \$140,000 for each home or individual unit in a multiple dwelling unit building.

Effective for tax periods beginning on or after January 1, 2003, the taxpayer must receive a tax credit certificate from the economic development authority to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.17(2). The tax credit certificate must be included with the income tax return for the tax period in which the home is ready for occupancy. The administrative rules for the eligible housing business tax credit for the economic development authority may be found under 261—Chapter 59.

42.17(2) *Transfer of the eligible housing business tax credit.* For tax periods beginning on or after January 1, 2003, the eligible housing business tax credit certificates may be transferred to any person or entity if low-income housing tax credits authorized under Section 42 of the Internal Revenue Code are used to assist in the financing of the housing development. In addition, the eligible housing business tax credit certificates may be transferred to any person or entity for projects beginning on or after July 1, 2005, if the housing development is located in a brownfield site as defined in Iowa Code section 15.291, or if the housing development is located in a blighted area as defined in Iowa Code section 403.17. No more than \$3 million of tax credits for housing developments located in brownfield sites or blighted areas may be transferred in a calendar year, with no more than \$1.5 million being transferred for any one eligible housing business in a calendar year.

The excess of the \$3 million limitation of tax credits eligible for transfer in the 2013 and 2014 calendar years for housing developments located in brownfield sites or blighted areas cannot be claimed by a transferee prior to January 1, 2016. The eligible housing business must have notified the economic development authority in writing before July 1, 2014, of the business's intent to transfer any tax credits for housing developments located in brownfield sites or blighted areas. If a tax credit certificate is issued by the economic development authority for a housing development approved prior to July 1, 2014, that is located in a brownfield site or blighted area, the tax credit can still be claimed by the eligible business, but the tax credit cannot be transferred by the eligible business if the economic development authority was not notified prior to July 1, 2014.

EXAMPLE 1: A housing development located in a brownfield site was completed in December 2013 and was issued a tax credit certificate totaling \$250,000. The \$3 million calendar cap for transferred tax credits for brownfield sites and blighted areas has already been reached for the 2013 and 2014 tax years. The \$250,000 tax credit is going to be transferred to Bill Smith, and the economic development authority was notified of the transfer prior to July 1, 2014. Once a replacement tax credit certificate has been issued, Mr. Smith cannot file an amended Iowa individual income tax return for the 2013 tax year until January 1, 2016, to claim the \$250,000 tax credit.

EXAMPLE 2: A housing development located in a blighted area was completed in May 2014 and was issued a tax credit certificate totaling \$150,000. The \$3 million calendar cap for transferred tax credits for brownfield sites and blighted areas has already been reached for the 2014 tax year. The \$150,000 tax credit is going to be transferred to Greg Rogers, and the economic development authority was notified of the transfer prior to July 1, 2014. Once a replacement tax credit certificate has been issued, Mr. Rogers cannot file an amended Iowa individual income tax return for the 2014 tax year until January 1, 2016, to claim the \$150,000 tax credit.

Within 90 days of transfer of the tax credit certificate for transfers prior to July 1, 2006, the transferee must submit the transferred tax credit certificate to the economic development authority, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. For transfers on or after July 1, 2006, the transferee must submit the transferred tax credit certificate to the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee for transfers prior to July 1, 2006, the economic development authority will issue a replacement tax credit certificate to the transferee. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the housing business tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credits shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes.

Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement 2014 Iowa Code section 15E.193B.
[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.18(422) Assistive device tax credit. Effective for tax years beginning on or after January 1, 2000, a taxpayer that is a small business that purchases, rents, or modifies an assistive device or makes workplace modifications for an individual with a disability who is employed or will be employed by the taxpayer may qualify for an assistive device tax credit, subject to the availability of the credit. The assistive device credit is equal to 50 percent of the first \$5,000 paid during the tax year by the small business for the purchase, rental, or modification of an assistive device or for making workplace modifications. Any credit in excess of the tax liability may be refunded or applied to the taxpayer's tax liability for the following tax year. If the taxpayer elects to take the assistive device tax credit, the taxpayer shall not deduct for Iowa income tax purposes any amount of the cost of an assistive device or workplace modification that is deductible for federal income tax purposes. A small business will not be eligible for the assistive device credit if the device is provided for an owner of the small business unless the owner is a bona fide employee of the small business.

42.18(1) Submitting applications for the credit. A small business that wishes to receive the assistive device tax credit must submit an application for the credit to the Iowa department of economic development and provide other information and documents requested by the Iowa department of economic development. If the taxpayer meets the criteria for qualification for the credit, the Iowa department of economic development will issue the taxpayer a certificate of entitlement for the credit. However, the aggregate amount of assistive device tax credits that may be granted by the Iowa department of economic development to all small businesses during a fiscal year cannot exceed \$500,000. The certificate of entitlement for the assistive device credit shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the estimated amount of the tax credit, the date on which the taxpayer's application was approved, the date when it is anticipated that the assistive device project will be completed and a space on the application where the taxpayer shall enter the date that the assistive device project was completed. The certificate of entitlement will not be considered to be valid for purposes of claiming the assistive device credit on the taxpayer's Iowa income tax return until the taxpayer has completed the assistive device project and has entered the completion date on the certificate of entitlement form. The tax year of the small business in which the assistive device project is completed is the tax year for which the assistive device credit may be claimed. For example, in a case where taxpayer A received a certificate of entitlement for an assistive device credit on September 15, 2007, and completed the assistive device workplace modification project on January 15, 2008, taxpayer A could claim the assistive device credit on taxpayer A's 2008 Iowa return, assuming that taxpayer A is filing returns on a calendar-year basis.

The department of revenue will not allow the assistive device credit on a taxpayer's return if the certificate of entitlement or a legible copy of the certificate is not included with the taxpayer's income tax return. If the taxpayer has been granted a certificate of entitlement and the taxpayer is a partnership, limited liability company, S corporation, estate, or trust, where the income of the taxpayer is taxed to the individual owner(s) of the business entity, the taxpayer must provide a copy of the certificate to each of the owners with a statement showing how the credit is to be allocated among the individual owners of the business entity. An individual owner shall include a copy of the certificate of entitlement and the statement of allocation of the assistive device credit with the individual's state income tax return.

42.18(2) Definitions. The following definitions are applicable to this rule:

"*Assistive device*" means any item, piece of equipment, or product system which is used to increase, maintain, or improve the functional capabilities of an individual with a disability in the workplace or on the job. "Assistive device" does not mean any medical device, surgical device, or organ implanted or transplanted into or attached directly to an individual. "Assistive device" does not include any device for which a certificate of title is issued by the state department of transportation, but does include any

item, piece of equipment, or product system otherwise meeting the definition of “assistive device” that is incorporated, attached, or included as a modification in or to such a device issued a certificate of title.

“*Business entity*” means partnership, limited liability company, S corporation, estate, or trust, where the income of the business is taxed to each of the individual owners of the business, whether the individual owner is a partner, member, shareholder, or beneficiary.

“*Disability*” means the same as defined in Iowa Code section 15.102. Therefore, “disability” means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of physical or mental impairment that substantially limits one or more of the major life activities of the individual, or being regarded as an individual with a physical or mental impairment that substantially limits one or more of the major life activities of the individual. “Disability” does not include any of the following:

1. Homosexuality or bisexuality.
2. Transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders, or other sexual behavior disorders.
3. Compulsive gambling, kleptomania, or pyromania.
4. Psychoactive substance abuse disorders resulting from current illegal use of drugs.
5. Alcoholism.

“*Employee*” means an individual who is employed by the small business and who meets the criteria in Treasury Regulation § 31.3401(c)-1(b), which is the definition of an employee for federal income tax withholding purposes. An individual who receives self-employment income from the small business shall not be considered an employee of the small business for purposes of this rule.

“*Small business*” means that the business either had gross receipts in the tax year before the current tax year of \$3 million or less or employed not more than 14 full-time employees during the tax year prior to the current tax year.

“*Workplace modifications*” means physical alterations to the office, factory, or other work environment where the disabled employee is working or will work.

42.18(3) Allocation of assistive tax credit to owners of a business entity. If the taxpayer that was entitled to an assistive device credit is a business entity, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner’s pro rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an assistive device credit of \$2,500 for a tax year and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an assistive device credit for the tax year of \$625 or 25 percent of the total assistive device credit of the partnership.

42.18(4) Repeal of credit. The assistive device credit is repealed on July 1, 2009.

This rule is intended to implement Iowa Code section 422.11E.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.19(404A,422) Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014. A historic preservation and cultural and entertainment district tax credit, subject to the availability of the credit, may be claimed against a taxpayer’s Iowa individual income tax liability for 25 percent of the qualified costs of rehabilitation of property to the extent the costs were incurred on or after July 1, 2000, for approved rehabilitation projects of eligible property in Iowa.

The general assembly has mandated that the department of cultural affairs and the department of revenue adopt rules to jointly administer Iowa Code chapter 404A. 2014 Iowa Acts, House File 2453, amended the historic preservation and cultural and entertainment district tax credit program effective July 1, 2014. The department of revenue’s provisions for projects with tax credits reserved prior to July 1, 2014, are found in this rule. The department of revenue’s provisions for projects with agreements entered into on or after July 1, 2014, are found in rule 701—42.54(404A,422). The department of cultural affairs’ rules related to this program may be found at 223—Chapter 48. Division I of 223—Chapter 48 applies to projects with reservations approved prior to July 1, 2014. Division II of 223—Chapter 48 applies to projects with agreements entered into on or after July 1, 2014.

Notwithstanding anything contained herein to the contrary, the department of cultural affairs shall not reserve tax credits under 2013 Iowa Code chapter 404A as amended by 2013 Iowa Acts, chapter 112, section 1, for applicants that do not have an approved Part 2 application and a tax credit reservation on or before June 30, 2014. Projects with approved Part 2 applications and provisional tax credit reservations on or before June 30, 2014, shall be governed by 2013 Iowa Code chapter 404A as amended by 2013 Iowa Acts, chapter 112, section 1; by 223—Chapter 48, Division I; and by rule 701—42.19(404A,422). Projects for which Part 2 applications were approved and agreements entered into after June 30, 2014, shall be governed by 2014 Iowa Acts, House File 2453; by 223—Chapter 48, Division II; and by rule 701—42.54(404A,422).

42.19(1) *Eligible properties for the historic preservation and cultural and entertainment district tax credit.* The following types of property are eligible for the historic preservation and cultural and entertainment district tax credit:

- a. Property verified as listed on the National Register of Historic Places or eligible for such listing.
- b. Property designated as of historic significance to a district listed in the National Register of Historic Places or eligible for such designation.
- c. Property or district designated a local landmark by a city or county ordinance.
- d. Any barn constructed prior to 1937.

42.19(2) *Application and review process for the historic preservation and cultural and entertainment district tax credit.*

a. Taxpayers who want to claim an income tax credit for completing a historic preservation and cultural and entertainment district project must submit an application for approval of the project. The application forms for the historic preservation and cultural and entertainment district tax credit may be requested from the State Tax Credit Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust, Des Moines, Iowa 50319-0290. The telephone number for this office is (515)281-4137. Applications for the credit will be accepted by the state historic preservation office on or after July 1, 2000, until such time as all the available credits allocated for each fiscal year are encumbered.

b. Applicants for the historic preservation and cultural and entertainment district tax credit must include all information and documentation requested on the application forms for the credit in order for the application to be processed.

42.19(3) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is 25 percent of the qualified rehabilitation costs made to an eligible property in a project. Qualified rehabilitation costs are those rehabilitation costs approved by the state historic preservation office for a project for a particular taxpayer to the extent those rehabilitation costs are actually expended by that taxpayer.

a. In the case of commercial property, qualified rehabilitation costs must equal at least \$50,000 or 50 percent of the assessed value of the property, excluding the value of the land, prior to rehabilitation, whichever is less. In the case of property other than commercial property, the qualified rehabilitation costs must equal at least \$25,000 or 25 percent of the assessed value, excluding the value of the land, prior to the rehabilitation, whichever amount is less.

b. In computing the tax credit, the only costs which may be included are the qualified rehabilitation costs incurred commencing from the date on which the first qualified rehabilitation cost is incurred and ending with the end of the taxable year in which the property is placed in service. The rehabilitation period may include dates that precede approval of a project, provided that any qualified rehabilitation costs incurred prior to the date of approval of the project are qualified rehabilitation costs.

c. For purposes of the historic preservation and cultural and entertainment district tax credit, qualified rehabilitation costs include those costs properly included in the basis of the eligible property for income tax purposes. Costs treated as expenses and deducted in the year paid or incurred and amounts that are otherwise not added to the basis of the property for income tax purposes are not qualified rehabilitation costs. Amounts incurred for architectural and engineering fees, site survey fees, legal expenses, insurance premiums, development fees, and other construction-related costs are

qualified rehabilitation costs to the extent they are added to the basis of the eligible property for tax purposes. Costs of sidewalks, parking lots, and landscaping do not constitute qualified rehabilitation costs. Any rehabilitation costs used in the computation of the historic preservation and cultural and entertainment district tax credit are not added to the basis of the property for Iowa income tax purposes if the rehabilitation costs were incurred in a tax year beginning on or after January 1, 2000, but prior to January 1, 2001. Any rehabilitation costs incurred in a tax year beginning on or after January 1, 2001, are added to the basis of the rehabilitated property for income tax purposes except those rehabilitation expenses that are equal to the amount of the computed historic preservation and cultural and entertainment district tax credit for the tax year.

EXAMPLE: The basis of a commercial building in a historic district was \$500,000, excluding the value of the land, before the rehabilitation project. During a project to rehabilitate this building, \$600,000 in rehabilitation costs were expended to complete the project and \$500,000 of those rehabilitation costs were qualified rehabilitation costs which were eligible for the historic preservation and cultural and entertainment district tax credit of \$125,000. Therefore, the basis of the building for Iowa income tax purposes was \$975,000, since the qualified rehabilitation costs of \$125,000, which are equal to the amount of the historic preservation and cultural and entertainment district tax credit for the tax year, are not added to the basis of the rehabilitated property. The basis of the building for federal income tax purposes was \$1,100,000. It should be noted that this example does not consider any possible reduced basis for the building for federal income tax purposes due to the rehabilitation investment credit provided in Section 47 of the Internal Revenue Code.

42.19(4) *Completion of the historic preservation and cultural and entertainment district project and claiming the historic preservation and cultural and entertainment district tax credit on the Iowa return.* After the taxpayer completes an authorized rehabilitation project, the taxpayer must be issued a certificate of completion of the project from the state historic preservation office of the department of cultural affairs. After verifying the taxpayer's eligibility for the historic preservation and cultural and entertainment district tax credit, the state historic preservation office shall issue a historic preservation and cultural and entertainment district tax credit certificate, which shall be included with the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the year the credit was reserved, whichever is later. For example, if a project was completed in 2008 and the credit was reserved for the state fiscal year ending June 30, 2010, the credit can be claimed on the 2009 calendar year return that is due on April 30, 2010. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed, the year the tax credit was reserved and the amount of the historic preservation and cultural and entertainment district tax credit. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee, the amount of the tax credit being transferred, and any consideration received in exchange for the tax credit, as provided in subrule 42.19(6). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, where the tax credit is allocated to the owners or beneficiaries of the entity, a list of the owners or beneficiaries and the amount of credit allocated to each owner or beneficiary shall be provided with the certificate. The tax credit certificate shall be included with the income tax return for the period in which the project was completed.

For tax years ending on or after July 1, 2007, any historic preservation and cultural and entertainment district tax credit in excess of the taxpayer's tax liability is fully refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.19(5) *Allocation of historic preservation and cultural and entertainment district tax credits to the individual owners of the entity for tax credits reserved for fiscal years beginning on or after July 1, 2012.* For tax credits reserved for fiscal years beginning on or after July 1, 2012, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. The credit does not have to be allocated based on the pro rata share of earnings of the partnership, limited liability company or S corporation.

42.19(6) *Transfer of the historic preservation and cultural and entertainment district tax credit.* For tax periods beginning on or after January 1, 2003, the historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. A tax credit certificate of less than \$1,000 shall not be transferable.

a. For transfers on or after July 1, 2006, the department of revenue will issue the replacement tax credit certificate to the transferee. Within 90 days of the transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue along with a statement containing the transferee's name, tax identification number and address, the denomination that each replacement tax credit certificate is to carry, the amount of all consideration provided in exchange for the tax credit and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the tax credit transferee shall describe the nature of nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The tax credit transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The replacement tax credit certificate must contain the same information that was on the original certificate and must have the same expiration date as the original tax credit certificate.

b. The transferee may use the amount of the tax credit for any tax period for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

c. If the historic preservation and cultural and entertainment district tax credit of the transferee exceeds the tax liability shown on the transferee's return, the tax credit shall be fully refundable.

This rule is intended to implement Iowa Code chapter 404A as amended by 2013 Iowa Acts, Senate File 436, and Iowa Code section 422.11D.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9104B**, IAB 9/22/10, effective 10/27/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0398C**, IAB 10/17/12, effective 11/21/12; **ARC 1138C**, IAB 10/30/13, effective 12/4/13; **ARC 1968C**, IAB 4/15/15, effective 5/20/15]

701—42.20(422) Ethanol blended gasoline tax credit. Effective for tax years beginning on or after January 1, 2002, a retail gasoline dealer may claim an ethanol blended gasoline tax credit against that individual's individual income tax liability. The taxpayer must operate at least one retail motor fuel site at which more than 60 percent of the total gallons of gasoline sold and dispensed through one or more motor fuel pumps by the taxpayer in the tax year is ethanol blended gasoline. The tax credit shall be calculated separately for each retail motor fuel site operated by the taxpayer. The amount of the credit for each eligible retail motor fuel site is two and one-half cents multiplied by the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at that retail motor fuel site during the tax year in excess of 60 percent of all gasoline sold and dispensed through motor fuel pumps at that retail motor fuel site during the tax year.

For taxpayers having a fiscal year ending in 2002, the tax credit is available for each eligible retail motor fuel site based on the total number of gallons of ethanol blended gasoline sold and dispensed through all motor fuel pumps located at the taxpayer's retail motor fuel site from January 1, 2002, until the end of the taxpayer's fiscal year. Assuming a tax period that began on July 1, 2001, and ended on June 30, 2002, the taxpayer would be eligible for the tax credit based on the gallons of ethanol blended gasoline sold from January 1, 2002, through June 30, 2002. For taxpayers having a fiscal year ending in

2002, a claim for refund to claim the ethanol blended gasoline tax credit must be filed before October 1, 2003, even though the statute of limitations for refund set forth in 701—subrule 43.3(8) has not yet expired.

EXAMPLE 1: A taxpayer sold 100,000 gallons of gasoline at the taxpayer's retail motor fuel site during the tax year, 70,000 gallons of which was ethanol blended gasoline. The taxpayer is eligible for the credit since more than 60 percent of the total gallons sold was ethanol blended gasoline. The number of gallons in excess of 60 percent of all gasoline sold is 70,000 less 60,000, or 10,000 gallons. Two and one-half cents multiplied by 10,000 equals a \$250 credit available.

The credit may be calculated on Form IA 6478. The credit must be calculated separately for each retail motor fuel site operated by the taxpayer. Therefore, if the taxpayer operates more than one retail motor fuel site, it is possible that one retail motor fuel site may be eligible for the credit while another retail motor fuel site may not. The credit may be taken only for those retail motor fuel sites for which more than 60 percent of gasoline sales involves ethanol blended gasoline.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

Starting with the 2006 calendar tax year, a taxpayer may claim the ethanol blended gasoline tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—42.31(422) for the same tax year for the same ethanol gallons.

EXAMPLE 2: A taxpayer sold 200,000 gallons of gasoline at a retail motor fuel site in 2006, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer is entitled to claim the ethanol blended gasoline tax credit of two and one-half cents multiplied by 40,000 gallons, since this amount constitutes the gallons in excess of 60 percent of the total gasoline gallons sold. Taxpayer may also claim the E-85 gasoline promotion tax credit on the 1,000 gallons of E-85 gasoline sold.

42.20(1) Definitions. The following definitions are applicable to this rule:

“*Ethanol blended gasoline*” means the same as defined in Iowa Code section 214A.1.

“*Gasoline*” means any liquid product prepared, advertised, offered for sale or sold for use as, or commonly and commercially used as, motor fuel for use in a spark-ignition, internal combustion engine, and which meets the specifications provided in Iowa Code section 214A.2.

“*Motor fuel pump*” means a pump, meter, or similar commercial weighing and measuring device used to measure and dispense motor fuel for sale on a retail basis.

“*Retail dealer*” means a person engaged in the business of storing and dispensing motor fuel from a motor fuel pump for sale on a retail basis, regardless of whether the motor fuel pump is located at a retail motor fuel site including a permanent or mobile location.

“*Retail motor fuel site*” means a geographic location in Iowa where a retail dealer sells and dispenses motor fuel on a retail basis. For example, tank wagons are considered retail motor fuel sites.

“*Sell*” means to sell on a retail basis.

42.20(2) Allocation of credit to owners of a business entity. If the taxpayer that was entitled to the ethanol blended gasoline tax credit is a partnership, limited liability company, S corporation, estate, or trust, the business entity shall allocate the allowable credit to each of the individual owners of the entity on the basis of each owner's pro rata share of the earnings of the entity to the total earnings of the entity. Therefore, if a partnership has an ethanol blended gasoline tax credit of \$3,000 and one partner of the partnership receives 25 percent of the earnings of the partnership, that partner would receive an ethanol blended gasoline tax credit for the tax year of \$750 or 25 percent of the total ethanol blended gasoline tax credit of the partnership.

42.20(3) Repeal of ethanol blended gasoline tax credit. The ethanol blended gasoline tax credit is repealed on January 1, 2009. However, the tax credit is available for taxpayers whose fiscal year ends after December 31, 2008, for those ethanol gallons sold beginning on the first day of the taxpayer's fiscal year until December 31, 2008. The ethanol promotion tax credit described in rule 701—42.37(15,422) is available beginning January 1, 2009, for retail dealers of gasoline.

See 701—subrule 52.19(3) for an example illustrating how this subrule is applied.

This rule is intended to implement Iowa Code section 422.11C.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.21(15E) Eligible development business investment tax credit. Effective for tax years beginning on or after January 1, 2001, a business which qualifies as an eligible development business may receive a tax credit of up to 10 percent of the new investment which is directly related to the construction, expansion or rehabilitation of building space to be used for manufacturing, processing, cold storage, distribution, or office facilities.

An eligible development business must be approved by the Iowa department of economic development prior to March 17, 2004, and meet the qualifications of Iowa Code section 15E.193C. Effective March 17, 2004, the eligible development business program is repealed.

New investment includes the purchase price of land and the cost of improvements made to real property. The tax credit may be claimed by an eligible development business in the tax year in which the construction, expansion or rehabilitation is completed.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

If the eligible development business fails to meet and maintain any one of the requirements to be an eligible business, the business shall be subject to repayment of all or a portion of the amount of tax incentives received. For example, if within five years of project completion the development business sells or leases any space to any retail business, the development business shall proportionally repay the value of the investment credit. The proportion of the investment credit that would be due for repayment by an eligible development business for selling or leasing space to a retail business would be determined by dividing the square footage of building space occupied by the retail business by the square footage of the total building space.

An eligible business which is not a development business and which operates in an enterprise zone cannot claim an investment tax credit if the property is owned, or was previously owned, by an approved development business that has already received an investment tax credit. An eligible business which is not a development business can claim an investment tax credit only on additional new improvements made to real property that was not included in the development business's approved application for the investment tax credit.

This rule is intended to implement Iowa Code section 15E.193C.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.22(15E,422) Venture capital credits.

42.22(1) *Investment tax credit for an equity investment in a qualifying business or community-based seed capital fund.*

a. Equity investments in a qualifying business or community-based seed capital fund before January 1, 2011. See rule 123—2.1(15E) for the discussion of the investment tax credit for an equity investment in a qualifying business or community-based seed capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board, for equity investments made before January 1, 2011. For equity investments made in a qualifying business prior to January 1, 2004, only direct investments made by an individual are eligible for the investment tax credit. Individuals receiving income from a revocable trust's investment in a qualifying business are eligible for the investment tax credit for the portion of the revocable trust's equity investment in a qualifying business.

b. Equity investments in a qualifying business or community-based seed capital fund on or after January 1, 2011, and before July 2, 2015. For equity investments made on or after January 1, 2011, see 261—Chapter 115 for information regarding eligibility for qualifying businesses and community-based seed capital funds, applications for the investment tax credit for equity investments in a qualifying

business or community-based seed capital fund, and the issuance of tax credit certificates by the economic development authority.

(1) Certificate issuance. The department of revenue will be notified by the economic development authority when the tax credit certificates are issued.

(2) Amount of the tax credit. The credit is equal to 20 percent of the taxpayer's equity investment in a qualifying business or community-based seed capital fund.

(3) Year in which the tax credit may be claimed. An investment shall be deemed to have been made on the same date as the date of acquisition of the equity interest as determined by the Internal Revenue Code. For investments made prior to January 1, 2014, a taxpayer shall not claim the tax credit prior to the third tax year following the tax year in which the investment is made. For investments made in qualifying businesses on or after January 1, 2014, the credit can be claimed in the year of the investment. However, for investments made in qualifying businesses during the 2014 calendar year, the credit cannot be redeemed prior to January 1, 2016. For example, if an individual taxpayer whose tax year ends on December 31, 2012, makes an equity investment during the 2012 calendar year, the individual taxpayer cannot claim the tax credit until the tax year ending December 31, 2015. However, if the taxpayer dies prior to redeeming the tax credit, the remaining tax credit may be redeemed on the decedent's final income tax return. For fiscal years beginning July 1, 2011, the amount of tax credits authorized cannot exceed \$2 million. The tax credit certificate must be included with the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

(4) Carried over tax credits. If a tax credit is carried over and issued for the tax year immediately following the year in which the investment was made because the \$2 million cap has been reached, the tax credit may be claimed by the taxpayer for the third tax year following the tax year for which the credit is issued. For example, if an individual taxpayer makes an equity investment in December 2012 and the \$2 million cap for the fiscal year ending June 30, 2013, had already been reached, the tax credit will be issued for the tax year ending December 31, 2013, and cannot be redeemed until the tax year ending December 31, 2016.

(5) Limitations. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit. The tax credit is not transferable to any other taxpayer.

(6) Pro rata tax credit claims for certain business entities. For equity investments made in a community-based seed capital fund or equity investments made in a qualifying business on or after January 1, 2004, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

c. Equity investments in a qualifying business on or after July 2, 2015. For equity investments made on or after July 2, 2015, see 261—Chapter 115 for information regarding eligibility for qualifying businesses, applications for the investment tax credit for equity investments in a qualifying business, and the issuance of tax credit certificates by the economic development authority.

(1) Certificate issuance. The department of revenue will be notified by the economic development authority when the tax credit certificates are issued.

(2) Amount of the tax credit. For fiscal years beginning July 1, 2011, the amount of the tax credits authorized cannot exceed \$2 million. The credit is equal to 25 percent of the taxpayer's equity investment in a qualifying business. In any one calendar year, the amount of tax credits issued for any one qualifying business shall not exceed \$500,000. The maximum amount of tax credit that may be issued per calendar year to a natural person and the person's spouse or dependent shall not exceed \$100,000 combined. For purposes of this paragraph, "dependent" has the same meaning as provided by the Internal Revenue Code.

(3) Year in which the tax credit may be claimed. A taxpayer shall not claim a tax credit prior to September 1, 2016. The tax credit certificate must be included with the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate. For purposes of this

paragraph, an investment shall be deemed to have been made on the same date as the date of acquisition of the equity interest as determined by the Internal Revenue Code.

(4) Pro rata tax credit claims for certain business entities. An individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust. Any credits claimed by an individual are subject to the limitations provided in 42.22(1) "c"(2) above.

(5) Refundability. For a tax credit claimed against the taxes imposed in Iowa Code chapter 422, division II, any tax credit in excess of the tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment shown on the taxpayer's final completed return credited to the tax liability for the following tax year.

(6) Transfers and carryback of tax credits prohibited. The tax credit cannot be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit. The tax credit is not transferable to any other taxpayer.

42.22(2) *Investment tax credit for an equity investment in a venture capital fund.* See rule 123—3.1(15E) for the discussion of the investment tax credit for an equity investment in a venture capital fund, along with the issuance of tax credit certificates by the Iowa capital investment board. This credit is repealed for investments in venture capital funds made after July 1, 2010.

The department of revenue will be notified by the Iowa capital investment board when the tax credit certificates are issued. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

For equity investments made in a venture capital fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.22(3) *Contingent tax credit for investments in Iowa fund of funds.* See rule 123—4.1(15E) for the discussion of the contingent tax credit available for investments made in the Iowa fund of funds organized by the Iowa capital investment corporation. Tax credit certificates related to the contingent tax credits will be issued by the Iowa capital investment board.

The department of revenue will be notified by the Iowa capital investment board when these tax credit certificates are issued and, if applicable, when they are redeemed. If the tax credit certificate is redeemed, the certificate must be attached to the taxpayer's return for the tax year in which the credit may be redeemed as stated on the tax credit certificate.

If the tax credit certificate is redeemed, any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until used, whichever is the earlier.

If the tax credit certificate is redeemed, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, or an estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

42.22(4) *Innovation fund investment tax credit.* See 261—Chapter 116 for information regarding eligibility for an innovation fund, applications for the investment tax credit for investments in an innovation fund, and the issuance of tax credit certificates by the economic development authority.

The department of revenue will be notified by the economic development authority when the tax credit certificates are issued. The credit is equal to 20 percent of the taxpayer's equity investment in the form of cash in an innovation fund for tax years beginning and investments made on or after January 1, 2011, and before January 1, 2013. For tax years beginning and investments made on or after January 1, 2013, the taxpayer may claim a tax credit equal to 25 percent of the taxpayer's equity investment in the

form of cash in an innovation fund. An investment shall be deemed to have been made on the same date as the date of acquisition of the equity interest as determined by the Internal Revenue Code. A taxpayer shall claim the tax credit for the tax year in which the investment is made. For fiscal years beginning July 1, 2011, the amount of tax credits authorized cannot exceed \$8 million. No tax credit certificates will be issued prior to September 1, 2014. The tax credit certificate must be attached to the taxpayer's return for the tax year in which the investment was made as stated on the tax credit certificate.

If a tax credit is carried over and issued for the tax year immediately following the year in which the investment was made because the \$8 million cap has been reached, the tax credit may be claimed by the taxpayer for the tax year following the tax year for which the credit is issued. For example, if an individual taxpayer makes an equity investment in December 2013 and the \$8 million cap for the fiscal year ending June 30, 2014, had already been reached, the tax credit will be issued for the tax year ending December 31, 2014, and can be redeemed for the tax year ending December 31, 2014.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until depleted, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit.

The innovation fund tax credit certificate may be transferred once to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the innovation fund tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

For equity investments made in an innovation fund, an individual may claim the credit if the investment was made by a partnership, S corporation, limited liability company, estate or trust electing to have the income directly taxed to the individual. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.51, 15E.52, 15E.66, 422.11F, and 422.11G and section 15E.43 as amended by 2015 Iowa Acts, chapter 138.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 9966B, IAB 1/11/12, effective 2/15/12; ARC 1102C, IAB 10/16/13, effective 11/20/13; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 2632C, IAB 7/20/16, effective 8/24/16]

701—42.23(15) New capital investment program tax credits. Effective for tax periods beginning on or after January 1, 2003, a business which qualifies under the new capital investment program is eligible to receive tax credits. An eligible business under the new capital investment program must be approved by the Iowa department of economic development and meet the qualifications of 2003 Iowa Acts, chapter 125, section 4. The new capital investment program was repealed on July 1, 2005, and has been replaced with the high quality job creation program. See rule 701—42.29(15) for information on the tax credits available under the high quality job creation program. Any tax credits earned by businesses approved

under the new capital investment program prior to July 1, 2005, remain valid and can be claimed on tax returns filed after July 1, 2005.

42.23(1) *Research activities credit.* A business approved under the new capital investment program is eligible for an additional research activities credit as described in 701—subrule 52.7(5). This credit for increasing research activities is in lieu of the research activities credit described in subrule 42.11(3).

42.23(2) *Investment tax credit.*

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in paragraph “b.” New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs “e” and “j,” purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

For eligible businesses approved by the Iowa department of economic development on or after March 17, 2004, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer’s cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual’s pro rata share of the individual’s earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust.

b. Tax credit percentage. The amount of tax credit claimed shall be based on the number of high quality jobs created as determined by the Iowa department of economic development:

(1) If no high quality jobs are created but economic activity within Iowa is advanced, the eligible business may claim a tax credit of up to 1 percent of the new investment.

(2) If 1 to 5 high quality jobs are created, the eligible business may claim a tax credit of up to 2 percent of the new investment.

(3) If 6 to 10 high quality jobs are created, the eligible business may claim a tax credit of up to 3 percent of the new investment.

(4) If 11 to 15 high quality jobs are created, the eligible business may claim a tax credit of up to 4 percent of the new investment.

(5) If 16 or more high quality jobs are created, the eligible business may claim a tax credit of up to 5 percent of the new investment.

c. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal

year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than \$4 million during a fiscal year to eligible businesses for this program and eligible businesses described in subrule 42.14(2). If applications are received for more than \$4 million, the applicants shall receive certificates for a prorated amount.

The economic development authority shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 42.14(2). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The economic development authority shall issue a tax credit certificate to each member on the list.

d. Repayment of benefits. If an eligible business fails to maintain the requirements of the new capital investment program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure to maintain the requirements of the new capital investment program. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.*, Docket No. 11DORF 042-044, June 11, 2012.

An eligible business in the new capital investment program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

- (1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.
- (2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.
- (3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.
- (4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.
- (5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

This rule is intended to implement Iowa Code section 15.333 as amended by 2010 Iowa Acts, Senate File 2380, and sections 15.335 and 15.381 to 15.387.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.24(15E,422) Endow Iowa tax credit. Effective for tax years beginning on or after January 1, 2003, a taxpayer who makes an endowment gift to an endow Iowa qualified community foundation may

qualify for an endow Iowa tax credit, subject to the availability of the credit. For tax years beginning on or after January 1, 2003, but before January 1, 2010, the credit is equal to 20 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, the credit is equal to 25 percent of a taxpayer's endowment gift to an endow Iowa qualified community foundation approved by the Iowa department of economic development. For tax years beginning on or after January 1, 2010, a taxpayer cannot claim a deduction for charitable contributions under Section 170 of the Internal Revenue Code for the amount of the contribution for which the tax credit is claimed for Iowa tax purposes. The administrative rules for the endow Iowa tax credit for the Iowa department of economic development may be found under 261—Chapter 47.

The total amount of endow Iowa tax credits available is \$2 million in the aggregate for the 2003 and 2004 calendar years. The total amount of endow Iowa tax credits is \$2 million annually for the 2005-2007 calendar years, and \$200,000 of these tax credits on an annual basis is reserved for endowment gifts of \$30,000 or less. The maximum amount of tax credit granted to a single taxpayer shall not exceed \$100,000 for the 2003-2007 calendar years. The total amount of endow Iowa tax credits annually for the 2008 and 2009 calendar years is \$2 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2010 is \$2.7 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The total amount of endow Iowa tax credits annually for 2011 is \$3.5 million plus a percentage of the tax imposed on the adjusted gross receipts from gambling games in accordance with Iowa Code section 99F.11(3). The maximum amount of tax credit granted to a single taxpayer shall not exceed 5 percent of the total endow Iowa tax credit amount authorized for 2008 and subsequent years. For the 2012 calendar year and subsequent calendar years, the total amount of endow Iowa tax credits is \$6 million; the maximum amount of tax credit authorized to a single taxpayer is \$300,000 (\$6 million multiplied by 5 percent). The endow Iowa tax credit cannot be transferred to any other taxpayer.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 15E.305 as amended by 2013 Iowa Acts, House File 620, and section 422.11H.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 9876B, IAB 11/30/11, effective 1/4/12; ARC 0398C, IAB 10/17/12, effective 11/21/12; ARC 1138C, IAB 10/30/13, effective 12/4/13]

701—42.25(422) Soy-based cutting tool oil tax credit. Effective for tax periods ending after June 30, 2005, and beginning before January 1, 2007, a manufacturer may claim a soy-based cutting tool oil tax credit. A manufacturer, as defined in Iowa Code section 428.20, may claim the credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.

All of the following conditions must be met to qualify for the tax credit:

1. The costs must be incurred after June 30, 2005, and before January 1, 2007.
2. The costs must be incurred in the first 12 months of the transition from using nonsoy-based cutting tool oil to using soy-based cutting tool oil.
3. The soy-based cutting tool oil must contain at least 51 percent soy-based products.
4. The costs of the purchase and replacement must not exceed \$2 per gallon of soy-based cutting tool oil used in the transition.
5. The number of gallons used in the transition cannot exceed 2,000 gallons.
6. The manufacturer shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based cutting tool oil which are deductible for federal tax purposes.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11I.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.26(15I,422) Wage-benefits tax credit. Effective for tax years ending on or after June 9, 2006, a wage-benefits tax credit equal to a percentage of the annual wages and benefits paid for a qualified new job created by the location or expansion of the business in Iowa is available for qualified businesses.

42.26(1) Definitions. The following definitions are applicable to this rule:

"Average county wage" means the annualized average hourly wage calculated by the Iowa department of economic development using the most current four quarters of wage and employment information as provided in the Quarterly Covered Wage and Employment Data report provided by the department of workforce development. Agricultural/mining and governmental employment categories are deleted in compiling the wage information.

"Benefits" means all of the following:

1. Medical and dental insurance plans.
2. Pension and profit-sharing plans.
3. Child care services.
4. Life insurance coverage.
5. Vision insurance plan.
6. Disability coverage.

"Department" means the Iowa department of revenue.

"Full-time" means the equivalent of employment of one person:

1. For 8 hours per day for a five-day, 40-hour workweek for 52 weeks per year, including paid holidays, vacations, and other paid leave, or
2. The number of hours or days per week, including paid holidays, vacations, and other paid leave, currently established by schedule, custom or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

"Grow Iowa values fund" means the grow Iowa values fund created in Iowa Code Supplement section 15G.108.

"Nonqualified new job" means any one of the following:

1. A job previously filled by the same employee in Iowa.
2. A job that was relocated from another location in Iowa.
3. A job that is created as a result of a consolidation, merger, or restructuring of a business entity if the job does not represent a new job in Iowa.

"Qualified new job" or *"job creation"* means a job that meets all of the following criteria:

1. Is a new full-time job that has not existed in the business in Iowa within the previous 12 months.
2. Is filled by a new employee for at least 12 months.
3. Is filled by a resident of the state of Iowa.
4. Is not created as a result of a change in ownership.
5. Was created on or after June 9, 2005.

"Retail business" means a business which sells its product directly to a consumer.

"Retained qualified new job" or *"job retention"* means the continued employment, after the first 12 months of employment, of the same employee in a qualified new job for another 12 months.

"Service business" means a business which is not engaged in the sale of tangible personal property, and which provides services to a local consumer market and does not have a significant proportion of its sales coming from outside Iowa.

42.26(2) Calculation of credit. A business which is not a retail or service business may claim the wage-benefits tax credit which is determined as follows:

a. If the annual wages and benefits for the qualified new job equal less than 130 percent of the average county wage, the credit is 0 percent of the annual wage and benefits paid.

b. If the annual wages and benefits for the qualified new job equal at least 130 percent but less than 160 percent of the average county wage, the credit is 5 percent of the annual wage and benefits paid for each qualified new job.

c. If the annual wages and benefits for the qualified new job equal at least 160 percent of the average county wage, the credit is 10 percent of the annual wage and benefits paid for each qualified new job.

If the business is a partnership, S corporation, limited liability company, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.26(3) Application for the tax credit; tax credit certificate; amount of tax credit available.

a. In order to claim the wage-benefits tax credit, the business must submit an application to the department along with information on the qualified new job or retained qualified new job. The application cannot be submitted until the end of the twelfth month after the qualified job was filled. For example, if the new job was created on June 9, 2005, the application cannot be submitted until June 9, 2006. The following information must be submitted in the application:

- (1) Name, address and federal identification number of the business.
- (2) A description of the activities of the business. If applicable, the proportion of the sales of the business which come from outside Iowa shall be included.
- (3) The amount of wages and benefits paid to each employee for each new job for the previous 12 months.
- (4) A computation of the amount of credit being requested.
- (5) The address and state of residence of each new employee.
- (6) The date that the qualified new job was filled.
- (7) An indication of whether the job is a qualified new job or a retained qualified new job for which an application was filed for a previous year.
- (8) The type of tax for which the credit will be applied.
- (9) If the business is a partnership, S corporation, limited liability company, or estate or trust, a schedule of the partners, shareholders, members or beneficiaries. This schedule shall include the names, addresses and federal identification numbers of the partners, shareholders, members or beneficiaries, along with their percentage of the pro rata share of earnings of the partnership, S corporation, limited liability company, or estate or trust.

b. Upon receipt of the application, the department has 45 days either to approve or deny the application. If the department does not act on the application within 45 days, the application is deemed approved. If the department denies the application, the business may appeal the decision to the Iowa economic development board within 30 days of the notice of denial.

c. If the application is approved, or if the Iowa economic development board approves the application that was previously denied by the department, a tax credit certificate will be issued by the department to the business, subject to the availability of the amount of credits that may be issued. The tax credit certificate shall contain the name, address and tax identification number of the business (or individual, estate or trust, if applicable), the date of the qualified new job(s), the wage and benefits paid for each job(s) for the 12-month period, the amount of the credit, the tax period for which the credit may be applied, and the type of tax for which the credit will be applied.

d. The tax credit certificates that are issued in a fiscal year cannot exceed \$10 million for the fiscal year ending June 30, 2007, and shall not exceed \$4 million for the fiscal years ending June 30, 2008, through June 30, 2011. The tax credit certificates are issued on a first-come, first-served basis. Therefore,

if tax credit certificates have already been issued for the \$10 million limit for the fiscal year ending June 30, 2007, any applications for tax credit certificates received after the \$10 million limit has been reached will be denied. Similarly, if tax credit certificates have already been issued for the \$4 million limit for the fiscal years ending June 30, 2008, through June 30, 2011, any applications for tax credit certificates received after the \$4 million limit has been reached will be denied. If a business failed to receive all or a part of the tax credit due to the \$10 million or \$4 million limitation, the business may reapply for the tax credit for the retained new job for a subsequent tax period.

e. A business which qualifies for the tax credit for the fiscal year ending June 30, 2007, is eligible to receive the tax credit certificate for each of the fiscal years ending June 30, 2008, through June 30, 2011, subject to the \$4 million limit for tax credits for the fiscal years ending June 30, 2008, through June 30, 2011, if the business retains the qualified new job during each of the fiscal years ending June 30, 2008, through June 30, 2011. The business must reapply by June 30 of each fiscal year for the tax credit, and the percentage of the wages and benefits allowed for the credit set forth in subrule 42.26(2) for the first year is applicable for each subsequent period. Preference will be given in issuing tax credit certificates for those businesses that retain qualified new jobs, and preference will be given in the order in which applications were filed for the fiscal year ending June 30, 2007. Therefore, those businesses which received the first \$4 million of tax credits for the year ending June 30, 2007, in which the qualified jobs were created will automatically receive a tax credit for the fiscal years ending June 30, 2008, through June 30, 2011, as long as the qualified jobs are retained and an application is completed.

f. For the fiscal years ending June 30, 2008, through June 30, 2011, if credits become available because the jobs were not retained by businesses which received the first \$4 million of credits for the year ending June 30, 2007, an application which was originally denied will be considered in the order in which the application was received for the fiscal year ending June 30, 2007.

EXAMPLE: Wage-benefits tax credits of \$4 million are issued for the fiscal year ending June 30, 2007, relating to applications filed between July 1, 2006, and March 31, 2007. For the next fiscal year ending June 30, 2008, the same businesses that received the \$4 million in wage-benefits tax credits filed applications totaling \$3 million for the retained jobs for which the application for the prior year was filed on or before March 31, 2007. The first \$3 million of the available \$4 million will be allowed to these same businesses. The remaining \$1 million that is still available for the fiscal year ending June 30, 2008, will be allowed for those retained jobs for which applications for the prior year were filed starting on April 1, 2007, until the remaining \$1 million in tax credits is issued.

g. A business may apply in writing to the Iowa economic development board for a waiver of the average wage and benefit requirement. If a waiver is granted, the business must provide the department with the waiver and it must be attached to the application.

h. A business may receive other federal, state, and local incentives and tax credits in addition to the wage-benefits tax credit. However, a business that receives a wage-benefits tax credit cannot receive tax incentives under the high quality job creation program set forth in Iowa Code chapter 15 or moneys from the grow Iowa values fund.

42.26(4) Examples. The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: Business A operates a grocery store and hires five new employees, each of whom will earn wages and benefits in excess of 130 percent of the average county wage. Business A would not qualify for the wage-benefits tax credit because Business A is a retail business.

EXAMPLE 2: Business B operates an accounting firm and hires two new accountants, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. The accounting firm provides services to clients wholly within Iowa. Business B would not qualify for the wage-benefits tax credit because it is a service business. The majority of its sales are generated from within the state of Iowa and thus Business B, because it is a service business, is not eligible for the credit.

EXAMPLE 3: Business C operates a software development business and hires two new programmers, each of whom will earn wages and benefits in excess of 160 percent of the average county wage. Over 50 percent of the customers of Business C are located outside Iowa. Business C would qualify for the wage-benefits tax credit because a majority of its sales are coming from outside the state, even though Business C is engaged in the performance of services.

EXAMPLE 4: Business D is a manufacturer that hires a new employee in Clayton County, Iowa, on July 8, 2005. The average county wage for Clayton County for the third quarter of 2005 is \$11.86 per hour. If the average county wage per hour for Clayton County is \$11.95 for the fourth quarter of 2005, \$12.05 for the first quarter of 2006, and \$12.14 for the second quarter of 2006, the annualized average county wage for this 12-month period is \$12.00 per hour. This wage equates to an average annual wage of \$24,960 ($\$12.00 \times 40 \text{ hours} \times 52 \text{ weeks}$). In order for Business D to qualify for the 5 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling \$32,448 (130 percent of \$24,960) for the 12-month period from July 8, 2005, through July 7, 2006. In order for Business D to qualify for the 10 percent wage-benefits tax credit, the new employee must receive wages and benefits totaling \$39,936 (160 percent of \$24,960) for the 12-month period from July 8, 2005, through July 7, 2006.

EXAMPLE 5: Business E is a manufacturer that hires three new employees in Grundy County, Iowa, on July 1, 2005. If the average county wage for the 12-month period from July 1, 2005, through June 30, 2006, is \$13.75 per hour in Grundy County, this wage equates to an average county wage of \$28,600. The wages and benefits for each of these three new employees is \$40,000 for the period from July 1, 2005, through June 30, 2006, which is 140 percent of the average county wage. Business E is entitled to a wage-benefits tax credit of \$2,000 for each employee ($\$40,000 \times 5 \text{ percent}$), for a total wage-benefits tax credit of \$6,000. If Business E files on a calendar-year basis, the \$6,000 wage-benefits tax credit can be claimed on the tax return for the period ending December 31, 2006.

EXAMPLE 6: Business F is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business F receives a wage-benefits tax credit in July 2006 for these ten employees, which can be used on the tax return for the period ending December 31, 2006. On August 31, 2006, two of the employees leave the business and are replaced by two new employees. Business F is entitled to a wage-benefits tax credit for only eight employees in July 2007 because only eight employees continued employment for the subsequent 12 months in a job which meets the definition of a retained qualified new job. Business F cannot request a wage-benefits tax credit for the two employees hired on August 31, 2006. Business F cannot request the wage-benefits tax credit because these two full-time jobs existed in the business within the previous 12 months in Iowa, and these jobs do not meet the definition of a qualified new job or retained qualified new job.

EXAMPLE 7: Business G is a manufacturer that hires ten new employees on July 1, 2005, and qualifies for the wage-benefits tax credit because the wages and benefits paid exceed 130 percent of the average county wage. Business G receives a wage-benefits tax credit in July 2006 for these ten employees equal to 5 percent of the wages and benefits paid. On October 1, 2006, Business G hires an additional five employees, each of whom receives wages and benefits in excess of 130 percent of the average county wage. Business G can apply for the wage-benefits tax credit on October 1, 2007, for these five employees, since these employees have now been employed for 12 months. However, the credit may not be allowed if more than \$4 million of retained job tax credits have been issued for the fiscal year ending June 30, 2008.

EXAMPLE 8: Assume the same facts as Example 6, except that the \$10 million limit of tax credits has already been met for the fiscal year ending June 30, 2007, and Business F hired five new employees on August 31, 2006. Business F can apply for the wage-benefits tax credit for the three employees on August 31, 2007, a number which is above the ten full-time jobs originally created, but Business F may not receive the tax credit if more than \$4 million of retained job tax credits have been issued for the fiscal year ending June 30, 2008.

EXAMPLE 9: Assume the same facts as Example 7, except that the ten employees hired on July 1, 2005, by Business G received wages and benefits equal to 155 percent of the average county wage, and the five employees hired on October 1, 2006, by Business G received wages equal to 161 percent of the average county wage. Business G can apply for the tax credit on October 1, 2007, equal to 10 percent of the wages and benefits paid for the employees hired on October 1, 2006. On July 1, 2007, Business G can reapply for the tax credit equal to 5 percent of the wages and benefits paid only for the ten employees

originally hired on July 1, 2005, even if the wages and benefits for these ten employees exceed 160 percent of the average county wage for the period from July 1, 2006, through June 30, 2007.

42.26(5) *Repeal of the wage-benefits tax credit.* The wage-benefits tax credit is repealed effective July 1, 2008. However, the wage-benefits tax credit is still available through the fiscal year ending June 30, 2011, as provided in subrule 42.26(3), paragraphs “d,” “e,” and “f.” A business is not entitled to a wage-benefits tax credit for a qualified new job created on or after July 1, 2008.

This rule is intended to implement Iowa Code chapter 15I and section 422.11L.
[ARC 8702B, IAB 4/21/10, effective 5/26/10]

701—42.27(422,476B) Wind energy production tax credit. Effective for tax years beginning on or after July 1, 2006, an owner of a qualified wind energy production facility that has been approved by the Iowa utilities board may claim a wind energy production tax credit for qualified electricity sold by the owner or used for on-site consumption against a taxpayer’s Iowa individual income tax liability. The administrative rules for the certification of eligibility for the wind energy production tax credit for the Iowa utilities board may be found in rule 199—15.18(476B).

42.27(1) *Application and review process for the wind energy production tax credit.* An owner of a wind energy production facility must be approved by the Iowa utilities board in order to qualify for the wind energy production tax credit. The facility must be an electrical production facility that produces electricity from wind, that is located in Iowa, and that is placed in service on or after July 1, 2005, but before July 1, 2012. For applications filed on or after March 1, 2008, a facility must consist of one or more wind turbines which have a combined nameplate generating capacity of at least 2 megawatts and no more than 30 megawatts. For applications filed on or after July 1, 2009, by a private college or university, community college, institution under the control of the state board of regents, public or accredited nonpublic elementary and secondary school, or public hospital as defined in Iowa Code section 249J.3, the facility must have a combined nameplate generating capacity of no less than $\frac{3}{4}$ of a megawatt.

The maximum amount of nameplate generating capacity for all qualified wind energy production facilities cannot exceed 50 megawatts. An owner shall not own more than two qualified facilities. A facility that is not operational within 18 months after issuance of the approval from the Iowa utilities board will no longer be considered a qualified facility. However, a facility that is not operational within 18 months due to the unavailability of necessary equipment shall be granted an additional 12 months to become operational.

An owner of the qualified facility must apply to the Iowa utilities board for the wind energy production tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.20(1).

42.27(2) *Computation of the credit.* The wind energy production credit equals one cent multiplied by the number of kilowatt-hours of qualified electricity sold or used for on-site consumption by the owner during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours of qualified electricity sold may exceed 12 months.

EXAMPLE: A qualified facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the period ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity sold between April 1, 2006, and December 31, 2007.

The credit is not allowed for any kilowatt-hours of electricity sold to a related person. The definition of “related person” uses the same criteria set forth in Section 45(e)(4) of the Internal Revenue Code relating to the federal renewable electricity production credit. Persons shall be treated as related to each other if such persons are treated as a single employer under Treasury Regulation § 1.52-1. In the case of a corporation that is a member of an affiliated group of corporations filing a federal consolidated return, such corporation shall be treated as selling electricity to an unrelated person if such electricity is sold to the person by another member of the affiliated group.

The utilities board will notify the department of the number of kilowatt-hours of electricity sold by the qualified facility or generated and used on site by the qualified facility during the tax year. The department

will calculate the credit and issue a tax credit certificate to the owner. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 42.27(3). If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.8(17A). The department will not issue a tax credit certificate if the facility is not operational within 18 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 42.27(1).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution, or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation, or the beneficiary's interest in the estate or trust.

The credit can be allowed for a ten-year period beginning on the date the qualified facility was originally placed in service. For example, if a facility was placed in service on April 1, 2006, the credit can be claimed for kilowatt-hours of electricity sold between April 1, 2006, and March 31, 2016.

To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax year set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

42.27(3) *Transfer of the wind energy production tax credit certificate.* The wind energy production tax credit certificate may be transferred to any person or entity.

Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the wind energy production tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax

purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

This rule is intended to implement Iowa Code section 422.11J and Iowa Code chapter 476B as amended by 2011 Iowa Acts, House File 672.

[**ARC 8702B**, IAB 4/21/10, effective 5/26/10; **ARC 9876B**, IAB 11/30/11, effective 1/4/12; **ARC 0251C**, IAB 8/8/12, effective 9/12/12; **ARC 1744C**, IAB 11/26/14, effective 12/31/14]

701—42.28(422,476C) Renewable energy tax credit. Effective for tax years beginning on or after July 1, 2006, a purchaser or producer of renewable energy whose facility has been approved by the Iowa utilities board may claim a renewable energy tax credit for qualified renewable energy against a taxpayer's Iowa individual income tax liability.

42.28(1) Eligible facility application process.

a. Eligible facility application process, generally. A producer or purchaser of a renewable energy facility must be approved as an eligible renewable energy facility by the Iowa utilities board in order to qualify for the renewable energy tax credit. The eligible renewable energy facility can be a wind energy conversion facility, biogas recovery facility, biomass conversion facility, methane gas recovery facility, solar energy conversion facility or refuse conversion facility. The facility must be located in Iowa and placed in service on or after July 1, 2005, and before January 1, 2018. The administrative rules for the certification of eligibility for the renewable energy tax credit for the Iowa utilities board may be found in rule 199—15.19(476C).

b. Limitations on maximum energy production and nameplate generating capacity. The maximum amount of nameplate generating capacity of all wind energy conversion facilities cannot exceed 363 megawatts. For tax years beginning prior to January 1, 2015, the maximum amount of energy production capacity for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities cannot exceed a combined output of 53 megawatts of nameplate generating capacity and 167 billion British thermal units of heat for a commercial purpose. For tax years beginning on or after January 1, 2015, the maximum amount of energy production for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities cannot exceed a combined output of 63 megawatts of nameplate generating capacity and, annually, 167 billion British thermal units of heat for a commercial purpose. A facility that is not operational within 30 months after issuance of approval from the utilities board will no longer be considered a qualified facility. However, if the facility is a wind energy conversion property and is not operational within 18 months due to the unavailability of necessary equipment, the facility may apply for a 12-month extension of the 30-month limit. Extensions can be renewed for succeeding 12-month periods if the facility applies for the extension prior to expiration of the current extension period. A producer of renewable energy, who is the person who owns the renewable energy facility, cannot own more than two eligible renewable energy facilities. A person that has an equity interest equal to or greater than 51 percent in an eligible renewable energy facility cannot have an equity interest greater than 10 percent in any other renewable energy facility. However, for tax years beginning on or after January 1, 2015, an entity described in Iowa Code section 476C.1(6) "b"(4) or (5) may have an ownership interest in up to four solar energy conversion facilities described in Iowa Code section 476C.3(4) "b"(3).

42.28(2) Tax credit certificate procedure.

a. Tax credit application process. A producer or purchaser of a renewable energy facility must apply to the utilities board for the renewable energy tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is applied. The information to be included in the application is set forth in 199—subrule 15.21(1). The utilities board will notify the department of the number of kilowatt-hours, standard cubic feet or British thermal units that were generated and purchased from an eligible facility or used for on-site consumption by the producer during the tax year for which the credit is applied.

b. Tax credit calculation. The department shall calculate the amount of the credit for which the applicant is eligible in accordance with subrules 42.28(3) and 42.28(4) and shall issue a tax credit certificate for that amount or shall notify the applicant in writing of its refusal to do so.

c. Tax credit certificate issuance. The tax credit certificate will include the taxpayer's name, address and federal identification number; the tax type for which the credit will be claimed; the amount of the credit; and the tax year for which the credit may be claimed. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit certificate, as provided in subrule 42.28(5). Once a tax credit certificate is issued pursuant to Iowa Code chapter 476C, it shall not be terminated or rescinded.

d. Taxpayers that are partnerships, limited liability companies, S corporations, or estates or trusts. If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust, except when the taxpayer is eligible to receive renewable electricity production tax credits authorized under Section 45 of the Internal Revenue Code. In cases where the taxpayer is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. In addition, if a taxpayer is a partnership, limited liability company, S corporation, or estate or trust that is eligible to receive renewable electricity production tax credits under Section 45 of the Internal Revenue Code, the taxpayer may distribute the tax credit to an equity holder or beneficiary as a liquidating distribution, or portion thereof, of an equity holder's interest in the partnership, limited liability company or S corporation or of the beneficiary's interest in the estate or trust.

e. Carryforward. To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for seven years or until it is used, whichever is the earlier.

42.28(3) Limitations.

a. Energy production. Of the maximum amount of energy production capacity equivalent for biogas recovery facilities, biomass conversion facilities, methane gas recovery facilities, solar energy conversion facilities and refuse conversion facilities:

(1) No single facility may be allocated more than ten megawatts of nameplate generating capacity or energy production capacity equivalent.

(2) For tax years beginning on or after January 1, 2015, ten megawatts of nameplate generating capacity or energy production capacity equivalent shall be reserved for solar energy conversion facilities described in Iowa Code section 476C.3(4) "b"(3) that have a generating capacity of one and one-half megawatts or less.

(3) For tax years, beginning on or after January 1, 2014, 55 billion British thermal units of heat for a commercial purpose shall be reserved annually for an eligible facility that is a refuse conversion facility for processed, engineered fuel from a multicounty solid waste management planning area.

(4) For tax years beginning on or after January 1, 2014, the maximum annual amount of energy production capacity for a single refuse conversion facility is 55 billion British thermal units of heat for a commercial purpose.

b. Related persons. The credit is not allowed for any kilowatt-hours, standard cubic feet or British thermal units that are purchased from an eligible facility by a related person. Persons shall be treated as related to each other if either person owns an 80 percent or more equity interest in the other person.

c. Operation. The facility must be operational within 30 months after approval was given by the utilities board, unless a 12-month extension is granted by the utilities board as provided in subrule 42.28(1).

d. Prohibited for persons that have received a credit under Iowa Code chapter 476B. A person that has received a wind energy production tax credit pursuant to Iowa Code chapter 476B may not be issued a renewable energy tax credit certificate.

e. Ten-year award limitation. The credit is allowed for a ten-year period beginning on the date the purchaser first purchases renewable energy from a qualified facility or on the date the qualified facility first began producing renewable energy for on-site consumption. For example, if a renewable energy facility first began producing energy for on-site consumption on April 1, 2006, the credit can be claimed for kilowatt-hours, standard cubic feet or British thermal units generated and used for on-site consumption by the producer between April 1, 2006, and March 31, 2016. Tax credit certificates cannot be issued for renewable energy purchased or produced for on-site consumption after December 31, 2027.

42.28(4) Computation of the credit. The renewable energy tax credit equals 1½ cents per kilowatt-hour of electricity, or \$1.44 per 1000 standard cubic feet of hydrogen fuel, or \$4.50 per 1 million British thermal units of methane gas or other biogas used to generate electricity, or \$4.50 per 1 million British thermal units of heat for a commercial purpose generated by and purchased from an eligible renewable energy facility or used for on-site consumption by the producer during the tax year. For the first tax year in which the credit is applied, the kilowatt-hours, standard cubic feet or British thermal units generated by and purchased from the facility or used for on-site consumption by the producer may exceed 12 months if the facility was operational for fewer than 12 months in its initial year of operation.

EXAMPLE: A qualified wind energy production facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which the credit can be claimed is the year ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include electricity generated and purchased or used for on-site consumption by the producer between April 1, 2006, and December 31, 2007.

42.28(5) Transfer of the renewable energy tax credit certificate.

a. One-transfer limitation. The renewable energy tax credit certificate may be transferred once to any person or entity. A decision between a producer and purchaser of renewable energy regarding who may claim the tax credit is not considered a transfer.

b. Transfer process—information required. Within 30 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department, along with a statement which contains the transferee's name, address and tax identification number; the amount of the tax credit being transferred; the value of any consideration provided by the transferee to the transferor; and any other information required by the department. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the renewable energy tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year and the same expiration date as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

c. Tax year. The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit.

d. Consideration. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.28(6) Small wind innovation zones. Effective for tax years beginning on or after January 1, 2009, an owner of a small wind energy system operating within a small wind innovation zone which has been approved by the Iowa utilities board is eligible for the renewable energy tax credit. The administrative rules of the Iowa utilities board for the certification of eligibility for owners of small wind energy systems operating within a small wind innovation zone may be found in rule 199—15.22(476).

42.28(7) Appeals. If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing, and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.8(17A).

This rule is intended to implement Iowa Code section 422.11J and Iowa Code chapter 476C as amended by 2015 Iowa Acts, chapter 124, and 2016 Iowa Acts, House File 2468.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9876B, IAB 11/30/11, effective 1/4/12; ARC 0251C, IAB 8/8/12, effective 9/12/12; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 2772C, IAB 10/12/16, effective 11/16/16]

701—42.29(15) High quality job creation program. Effective for tax periods ending on or after July 1, 2005, for programs approved on or after July 1, 2005, but before July 1, 2009, a business which qualifies under the high quality job creation program is eligible to receive tax credits. The high quality job creation program replaces the new jobs and income program and the new capital investment program. An eligible business under the high quality job creation program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The administrative rules for the high quality job creation program for the Iowa department of economic development may be found at 261—Chapter 68.

The high quality job creation program was repealed on July 1, 2009, and has been replaced with the high quality jobs program. See rule 701—42.42(15) for information on the investment tax credit and additional research activities credit under the high quality jobs program. Any investment tax credit and additional research activities credit earned by businesses approved under the high quality job creation program prior to July 1, 2009, remains valid and can be claimed on tax returns filed after July 1, 2009.

42.29(1) Research activities credit. An eligible business approved under the high quality job creation program is eligible for an additional research activities credit as described in 701—subrule 52.7(4).

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate generating capacity. The research activities credit related to renewable energy generation components under the high quality job creation program and the enterprise zone program shall not exceed \$1 million in the aggregate.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs “a” and “b.” The research activities credit is subject to the threshold amounts of qualifying investment set forth in Iowa department of economic development 261—subrule 68.4(7).

42.29(2) Investment tax credit.

a. General rule. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7). New investment directly related to new jobs created by the location or expansion of an eligible business includes the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1(1), paragraphs “e” and “j,” purchased for use in the operation of the eligible business. The purchase price shall be depreciated in accordance with generally accepted accounting principles.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the eligible business.

In addition, certain lease payments made by eligible businesses to a third-party developer will be considered to be new investment for purposes of computing the investment tax credit. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years. The investment tax credit is based on the annual base rent paid to a third-party developer by the eligible

business for a period not to exceed ten years. The total costs of the annual base rent payments for the ten-year period cannot exceed the cost of the land and the third-party developer's cost to build or renovate the building used by the eligible business. The annual base rent is defined as the total lease payment less taxes, insurance and operating and maintenance expenses.

The investment tax credit can be claimed in the tax year in which the qualifying assets are placed in service. The investment tax credit will be amortized over a five-year period. Any credit in excess of the tax liability for the tax period may be carried forward seven years or until used, whichever is the earlier.

EXAMPLE: An eligible business which files tax returns on a calendar-year basis earned \$100,000 of investment tax credits for new investment made in 2006. The business can claim \$20,000 of investment tax credits for each of the years from 2006 through 2010. The \$20,000 of investment tax credit that can be claimed in 2006 can be carried forward to the 2007-2013 tax years if the entire credit cannot be claimed on the 2006 return. Similarly, the \$20,000 investment tax credit that can be claimed in 2007 can be carried forward to the 2008-2014 tax years if the entire credit cannot be claimed on the 2007 return.

If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual, an individual may claim the credit. The amount of the credit claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to an individual.

b. Investment tax credit—value-added agricultural products or biotechnology-related processes. An eligible business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund for all or a portion of an unused investment tax credit. An eligible business includes a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol.

Eligible businesses that elect to receive a refund shall apply to the Iowa department of economic development for tax credit certificates between May 1 and May 15 of each fiscal year through the fiscal year ending June 30, 2009. The election to receive a refund of all or a portion of an unused investment tax credit is no longer available beginning with the fiscal year ending June 30, 2010. Only those businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. The Iowa department of economic development shall not issue tax credit certificates for more than \$4 million during a fiscal year to eligible businesses for this program and the enterprise zone program described in subrule 42.14(2). If applications are received for more than \$4 million, the applicants shall receive certificates for a prorated amount.

The economic development authority shall issue tax credit certificates within a reasonable period of time. Tax credit certificates are valid for the tax year following project completion. The tax credit certificate must be included with the tax return for the tax year during which the tax credit is claimed. The tax credit certificate shall not be transferred, except for a cooperative described in Section 521 of the Internal Revenue Code whose project primarily involves the production of ethanol, as provided in subrule 42.14(2). For value-added agricultural projects involving ethanol, the cooperative must submit a list of its members and the share of each member's interest in the cooperative. The economic development authority shall issue a tax credit certificate to each member on the list.

c. Repayment of benefits. If an eligible business fails to maintain the requirements of the high quality job creation program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure of the eligible business to maintain the requirements of the high quality job creation program because the repayment is a recovery of an incentive, rather than an adjustment to the taxpayer's tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners,

members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.*, Docket No. 11DORF 042-044, June 11, 2012.

An eligible business in the high quality job creation program may also be required to repay all or a portion of the tax incentives received on Iowa returns if the eligible business experiences a layoff of employees in Iowa or closes any of its facilities in Iowa.

If, within five years of purchase, the eligible business sells, disposes of, razes, or otherwise renders unusable all or a part of the land, buildings, or other existing structures for which a tax credit was claimed under this subrule, the income tax liability of the eligible business shall be increased by one of the following amounts:

(1) One hundred percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within one full year after being placed in service.

(2) Eighty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within two full years after being placed in service.

(3) Sixty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within three full years after being placed in service.

(4) Forty percent of the tax credit claimed if the property ceases to be eligible for the tax credit within four full years after being placed in service.

(5) Twenty percent of the investment tax credit claimed if the property ceases to be eligible for the tax credit within five full years after being placed in service.

42.29(3) Determination of tax credit amounts. The amount of tax credit claimed under the high quality job creation program shall be based on the number of high quality jobs created and the amount of qualifying investment made as determined by the Iowa department of economic development.

a. If the high quality jobs have a starting wage, including benefits, equal to or greater than 130 percent of the average county wage but less than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7) “a” for the amount of tax credits that may be claimed.

b. If the high quality jobs have a starting wage, including benefits, equal to or greater than 160 percent of the average county wage, see Iowa department of economic development 261—paragraph 68.4(7) “b” for the amount of tax credits that may be claimed.

c. An eligible business approved under the high quality job creation program is not eligible for the wage-benefits tax credit set forth in rule 701—42.26(15I,422).

This rule is intended to implement Iowa Code sections 15.326 to 15.337.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.30(15E,422) Economic development region revolving fund tax credit. Effective for tax years ending on or after July 1, 2005, but beginning before January 1, 2010, a taxpayer who makes a contribution to an economic development region revolving fund may claim a tax credit, subject to the availability of the credit. The tax credit is equal to 20 percent of a taxpayer’s contribution to the economic development region revolving fund approved by the Iowa department of economic development. The administrative rules for the economic development region revolving fund tax credit for the Iowa department of economic development may be found at 261—Chapter 32. The tax credit is repealed for tax years beginning on or after January 1, 2010.

The total amount of economic development region revolving fund tax credits available shall not exceed \$2 million per fiscal year. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit. The economic development region revolving fund tax credit is not transferable to any other taxpayer.

Any tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier.

If a taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount

claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code sections 15E.232 and 422.11K as amended by 2010 Iowa Acts, Senate File 2380.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10]

701—42.31(422) Early childhood development tax credit. Taxpayers may claim a tax credit equal to 25 percent of the first \$1,000 of expenses paid to others for early childhood development for each dependent three to five years of age. The credit is available only to taxpayers whose net income is less than \$90,000. If a taxpayer claims the early childhood development tax credit, the taxpayer cannot claim the child and dependent care credit described in rule 701—42.15(422). The early childhood development tax credit is refundable to the extent that the credit exceeds the taxpayer's income tax liability.

For married taxpayers who elect to file separately on a combined form or elect to file separate returns for Iowa tax purposes, the combined net income of the taxpayers must be less than \$90,000 to be eligible for the credit. If the combined net income is less than \$90,000, the early childhood development tax credit shall be prorated to each spouse in the proportion that each spouse's respective net income bears to the total combined net income.

Nonresidents and part-year residents who have income from Iowa sources in the tax year may claim the early childhood development tax credit on their Iowa returns. If the taxpayer's all-source net income is \$90,000 or higher, the taxpayer will not qualify for the credit. Nonresidents or part-year residents of Iowa must determine the early childhood development tax credit in the ratio of their Iowa-source net income to their all-source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or to file separately on a combined Iowa return, the early childhood development tax credit must be allocated between the spouses in the ratio of each spouse's Iowa-source net income to their combined Iowa-source net income.

42.31(1) Expenses eligible for the credit. The following expenses qualify for the early childhood development tax credit, to the extent they are paid during the time period that a dependent is either three, four, or five years of age:

a. Expenses for services provided by a preschool, as defined in Iowa Code section 237A.1. The preschool may only provide services for periods of time not exceeding three hours per day.

b. Books that improve child development, including textbooks, music books, art books, teacher editions, and reading books.

c. Expenses paid for instructional materials required to be used in a child development or educational lesson activity. These materials include, but are not limited to, paper, notebooks, pencils, and art supplies. In addition, software and toys which are directly and primarily used for educational or learning purposes are considered instructional materials.

d. Expenses paid for lesson plans and curricula.

e. Expenses paid for child development and educational activities outside the home. These activities include, but are not limited to, drama, art, music, and museum activities, including the entrance fees for such activities.

42.31(2) Expenses not eligible for the credit. The following expenses do not qualify for the early childhood development tax credit:

a. Any expenses, including expenses paid to a preschool, once a dependent reaches the age of six.

b. Expenses relating to food, lodging, membership fees, or other nonacademic expenses relating to child development and educational activities outside the home.

c. Expenses related to services, materials, or activities for the teaching of religious tenets, doctrines, or worship, in cases where the purpose of the teaching is to inculcate the religious tenets, doctrines, or worship.

This rule is intended to implement Iowa Code section 422.12C.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 6149C, IAB 1/12/22, effective 2/16/22]

701—42.32(422) School tuition organization tax credit. For tax years beginning prior to January 1, 2021, a school tuition organization tax credit is available which is equal to 65 percent of the amount of

voluntary cash or noncash contributions made by a taxpayer to a school tuition organization. For tax years beginning on or after January 1, 2021, the tax credit is equal to 75 percent of the amount of voluntary cash or noncash contributions made by a taxpayer to a school tuition organization. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a noncash contribution, and these are equally applicable to the determination of the amount of a school tuition organization tax credit.

42.32(1) Definitions. The following definitions are applicable to this rule:

“Certified enrollment” means the enrollment at schools served by school tuition organizations as of October 1, or the first Monday in October if October 1 falls on a Saturday or Sunday, of the appropriate year.

“Contribution” means a voluntary cash or noncash contribution to a school tuition organization that is not used for the direct benefit of any dependent of the taxpayer or any other student designated by the taxpayer.

“Eligible student” means a student residing in Iowa who is a member of a household whose total annual income during the calendar year prior to the school year in which the student receives a tuition grant from a school tuition organization does not exceed an amount equal to four times the most recently published federal poverty guidelines in the Federal Register by the United States Department of Health and Human Services.

“Qualified school” means a nonpublic elementary or secondary school in Iowa which is accredited under Iowa Code section 256.11, including a prekindergarten program for students who are five years of age by September 15 of the appropriate year, and adheres to the provisions of the federal Civil Rights Act of 1964 and Iowa Code chapter 216, and which is represented by only one school tuition organization.

“School tuition organization” means a charitable organization in Iowa that is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code and that does all of the following:

1. Allocates at least 90 percent of its annual revenue in tuition grants for children to allow them to attend a qualified school of their parents’ choice.
2. Awards tuition grants only to children who reside in Iowa.
3. Provides tuition grants to students without limiting availability to students of only one school.
4. Provides tuition grants only to eligible students.
5. Prepares an annual financial statement certified by a public accounting firm.

“Tuition grant” means a grant to a student to cover all or part of the student’s tuition at a qualified school.

42.32(2) Initial registration. In order for contributions to a school tuition organization to qualify for the credit, the school tuition organization must initially register with the department. The following information must be provided with this initial registration:

- a. Verification from the Internal Revenue Service that Section 501(c)(3) status was granted and that the school tuition organization is exempt from federal income tax.
- b. A list of all qualified schools that the school tuition organization serves.
- c. The names and addresses of all the members of the board of directors of the school tuition organization.

Once the school tuition organization is registered with the department, it is not required to subsequently register unless there is a change in the qualified schools that the organization serves. The school tuition organization must notify the department in writing of any changes in the qualified schools it serves.

42.32(3) Participation forms. Each qualified school that is served by a school tuition organization must annually submit a participation form to the department by November 1. The following information must be provided with this participation form:

- a. The certified enrollment of the qualified school as of October 1, or the first Monday in October if October 1 falls on a Saturday or Sunday.
- b. The name of the school tuition organization that represents the qualified school.

42.32(4) Authorization to issue tax credit certificates.

a. By December 1 of each year, the department will authorize school tuition organizations to issue tax credit certificates for the following calendar year. The total amount of tax credit certificates that may be authorized is:

- (1) \$2.5 million for the 2006 calendar year,
- (2) \$5 million for the 2007 calendar year,
- (3) \$7.5 million for the 2008 through 2011 calendar years,
- (4) \$8.75 million for the 2012 and 2013 calendar years,
- (5) \$12 million for the 2014 through 2018 calendar years,
- (6) \$13 million for the 2019 calendar year,
- (7) \$15 million for the 2020 and 2021 calendar years, and
- (8) \$20 million for the 2022 calendar year and subsequent calendar years.

b. The amount of authorized tax credit certificates for each school tuition organization is determined by dividing the total amount of tax credit available by the total certified enrollment of all qualified participating schools. This result, which is the per-student tax credit, is then multiplied by the certified enrollment of each school tuition organization to determine the tax credit authorized to each school tuition organization.

EXAMPLE: For determining the authorized tax credits for the 2022 calendar year, if the certified enrollment of all qualified schools in Iowa, as provided to the department by November 1, 2021, was 40,000, the per-student tax credit would be \$500 ($\$20 \text{ million} \div 40,000$). If a school tuition organization located in Scott County represents four qualified schools with a certified enrollment of 1,400 students, the school tuition organization would be authorized to issue \$700,000 ($\$500 \times 1,400$) of tax credit certificates for the 2022 calendar year. The department would notify this school tuition organization by December 1, 2021, of the authorization to issue \$700,000 of tax credit certificates for the 2022 calendar year. This authorization would allow the school tuition organization to solicit contributions totaling \$933,333 ($\$700,000 \div 75\%$) during the 2022 calendar year which would be eligible for the tax credit.

42.32(5) Issuance of tax credit certificates.

a. The school tuition organization shall issue tax credit certificates to each taxpayer who made a cash or noncash contribution to the school tuition organization. The tax credit certificate, designed by the department, shall contain the name, address and tax identification number of the taxpayer; the amount and date that the contribution was made; the amount of the credit; the tax year that the credit may be applied; the school tuition organization to which the contribution was made; and the tax credit certificate number.

b. A tax credit certificate may be issued to a partnership, limited liability company, S corporation, estate or trust. The amount of credit claimed by an individual shall be based on the pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate or trust.

42.32(6) Claiming the tax credit. The taxpayer must include the tax credit certificate with the tax return for which the credit is claimed. The tax credit shall be claimed in the tax year during which the contribution is made. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier.

a. The taxpayer shall not claim an itemized deduction for charitable contributions for Iowa income tax purposes for the amount of the contribution made to the school tuition organization.

b. Married taxpayers who file separate returns or file separately on a combined return must allocate the school tuition organization tax credit to each spouse in the proportion that each spouse's respective net income bears to the total combined net income. Nonresidents or part-year residents of Iowa, including those who are claiming a tax credit of a partnership, limited liability company, S corporation, estate, or trust of which they are a member, must determine the school tuition organization tax credit in the ratio of their Iowa source net income to their total source net income. In addition, if nonresidents or part-year residents of Iowa are married and elect to file separate returns or to file separately on a combined return, the school tuition organization tax credit must be allocated between the spouses in the ratio of each spouse's Iowa source net income to the combined Iowa source net income.

42.32(7) Reporting requirements. Each school tuition organization that issues tax credit certificates must report to the department, postmarked by January 12 of each calendar year, the following information:

- a. The names and addresses of all the members of the board of directors of the school tuition organization, along with the name of the chairperson of the board.
- b. The total number and dollar value of contributions received by the school tuition organization for the previous calendar year.
- c. The total number and dollar value of tax credit certificates issued by the school tuition organization for the previous calendar year.
- d. A list of each taxpayer who received a tax credit certificate for the previous calendar year, including the amount of the contribution and the amount of tax credit issued to each taxpayer for the previous calendar year. This list should also include the tax identification number of the taxpayer and the tax credit certificate number for each certificate.
- e. The total number of children utilizing tuition grants for the school year in progress as of January 12, along with the total dollar value of the tuition grants.
- f. The name and address of each qualified school represented by the school tuition organization at which tuition grants are being utilized for the school year in progress.
- g. The number of tuition grant students and the total dollar value of tuition grants being utilized for the school year in progress at each qualified school served by the school tuition organization.

This rule is intended to implement Iowa Code section 422.11S.
 [ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9876B, IAB 11/30/11, effective 1/4/12; ARC 1102C, IAB 10/16/13, effective 11/20/13; ARC 1744C, IAB 11/26/14, effective 12/31/14; ARC 5978C, IAB 10/20/21, effective 11/24/21]

701—42.33(422) E-85 gasoline promotion tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of gasoline may claim an E-85 gasoline promotion tax credit. “E-85 gasoline” means ethanol blended gasoline formulated with a minimum percentage of between 70 percent and 85 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 135.

42.33(1) Claiming the credit.

a. *Amount of the credit.* The credit is calculated by multiplying the total number of E-85 gallons sold by the retail dealer during the tax year by the following designated rates:

Calendar years 2006, 2007, and 2008	25 cents
Calendar years 2009 and 2010	20 cents
Calendar year 2011	10 cents
Calendar years 2012 through 2024	16 cents

b. *Claiming the credit with other credits.* A taxpayer may claim the E-85 gasoline promotion tax credit even if the taxpayer also claims the ethanol blended gasoline tax credit provided in rule 701—42.20(422) for gallons sold prior to January 1, 2009, or the ethanol promotion tax credit provided in rule 701—42.39(422) for gallons sold on or after January 1, 2009, but prior to January 1, 2021, for the same tax year for the same ethanol gallons.

c. *Refundability.* Any credit in excess of the taxpayer’s tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

d. *Transferability.* The credit may not be transferred to any other person.

e. *Example.* A taxpayer operated one retail motor fuel site in 2008 and sold 200,000 gallons of gasoline, of which 160,000 gallons was ethanol blended gasoline. Of these 160,000 gallons, 1,000 gallons was E-85 gasoline. Taxpayer may claim the E-85 gasoline promotion tax credit on the 1,000 gallons of E-85 gasoline sold during 2008. Taxpayer is also entitled to claim the ethanol blended gasoline

tax credit of two and one-half cents multiplied by 40,000 gallons, since this constitutes the gallons in excess of 60 percent of the total gasoline gallons sold for the 2008 tax year.

42.33(2) Fiscal year filers. For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-85 gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2025, a taxpayer whose tax year ends prior to December 31, 2024, may continue to claim the tax credit in the following tax year for any E-85 gallons sold through December 31, 2024. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-85 credit on the previous return, the dealer may claim the credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

See 701—subrule 52.30(2) for examples illustrating how this subrule is applied.

42.33(3) Allocation of credit to owners of a business entity or to beneficiaries of an estate or trust. If a taxpayer claiming the E-85 ethanol promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11O as amended by 2016 Iowa Acts, Senate File 2309.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9821B, IAB 11/2/11, effective 12/7/11; ARC 3043C, IAB 4/26/17, effective 5/31/17]

701—42.34(422) Biodiesel blended fuel tax credit. Effective for tax years beginning on or after January 1, 2006, a retail dealer of biodiesel blended fuel may claim a biodiesel blended fuel tax credit. "Biodiesel blended fuel" means a blend of biodiesel with petroleum-based diesel fuel that meets the standards provided in Iowa Code section 214A.2. In determining the minimum percentage by volume of biodiesel, the department will take into account reasonable variances due to testing and other limitations. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 8864.

42.34(1) Calculating the credit.

a. Gallonage requirement.

(1) Tax years beginning on or after January 1, 2006, but prior to January 1, 2009. In order for a retail dealer to qualify for the biodiesel blended fuel tax credit for tax years beginning on or after January 1, 2006, but prior to January 1, 2009, of the total gallons of diesel fuel that the retail dealer sells and dispenses during the tax year, 50 percent or more of those gallons must be biodiesel blended fuel formulated with a minimum percentage of 2 percent by volume of biodiesel. The gallonage amounts for all motor fuel sites of a retail dealer are combined when calculating this gallonage requirement.

(2) Tax years beginning on or after January 1, 2009, but prior to January 1, 2012. For tax years beginning on or after January 1, 2009, but prior to January 1, 2012, the biodiesel blended fuel tax credit is calculated separately for each retail motor fuel site for which 50 percent or more of the total gallons of diesel fuel sold at the motor fuel site was biodiesel blended fuel formulated with a minimum percentage of 2 percent by volume of biodiesel.

(3) Tax years beginning on or after January 1, 2012. For tax years beginning on or after January 1, 2012, the requirement that 50 percent of all diesel fuel gallons sold be biodiesel gallons to be eligible for the tax credit is eliminated. A retail dealer may qualify for the biodiesel blended fuel tax credit even if the number of gallons of biodiesel blended fuel sold is less than 50 percent of the total gallons of diesel fuel sold.

b. Amount of credit.

(1) Fuel sold on or after January 1, 2006, but prior to January 1, 2012. For biodiesel blended fuel sold on or after January 1, 2006, but prior to January 1, 2012, the tax credit equals three cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the

tax year. Qualifying biodiesel blended fuel must be formulated with a minimum percentage of 2 percent by volume of biodiesel.

(2) Fuel sold on or after January 1, 2012, but prior to January 1, 2013. For biodiesel blended fuel sold on or after January 1, 2012, but prior to January 1, 2013, the tax credit equals the sum of two cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year that have a minimum percentage of 2 percent by volume of biodiesel but less than 5 percent by volume of biodiesel plus four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year that have a minimum percentage of 5 percent by volume of biodiesel. In addition, the gallonage requirements described in paragraph 42.34(1) "a" do not apply to fuel sold on or after January 1, 2012.

(3) Fuel sold on or after January 1, 2013, but prior to January 1, 2018. For biodiesel blended fuel sold on or after January 1, 2013, but prior to January 1, 2018, the tax credit equals four and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year that have a minimum percentage of 5 percent by volume of biodiesel. Diesel fuel sold that contains less than 5 percent by volume of biodiesel does not qualify for the biodiesel blended fuel tax credit.

(4) Fuel sold on or after January 1, 2018, but prior to January 1, 2025.

1. Amount of credit. For biodiesel blended fuel sold on or after January 1, 2018, but prior to January 1, 2025, the tax credit equals the sum of three and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year that have a minimum percentage of 5 percent by volume of biodiesel but less than 11 percent by volume of biodiesel plus five and one-half cents multiplied by the qualifying number of biodiesel blended fuel gallons sold by the taxpayer during the tax year that have a minimum percentage of 11 percent by volume of biodiesel. Diesel fuel sold that contains less than 5 percent by volume of biodiesel does not qualify for the biodiesel blended fuel tax credit.

2. Blending errors. Where a blending error occurs and an insufficient amount of biodiesel has inadvertently been blended with petroleum-based diesel fuel so that the mixture fails to contain 11 percent by volume of biodiesel, a 1 percent tolerance applies in determining the credit amount for the blended product as described in 42.34(1) "b"(4)"2":

- If the amount of the biodiesel erroneously blended with petroleum-based diesel is at least 10 percent of the total blended product by volume, the entire blended product qualifies for the credit amount available for biodiesel blended fuel that has a minimum percentage of 11 percent by volume of biodiesel.

- If the amount of biodiesel blended with petroleum-based diesel is at least 5 percent but less than 10 percent of the total blended product by volume, the entire blended product qualifies for the credit amount available for biodiesel blended fuel that has a minimum percentage of 5 percent by volume of biodiesel but less than 11 percent by volume of biodiesel.

- Numbered paragraph 42.34(1) "b"(4)"2" applies only if a retail dealer intends to sell and dispense biodiesel blended fuel that has a minimum percentage of 11 percent by volume of biodiesel. If a retail dealer does not intend to sell and dispense biodiesel blended fuel that has a minimum percentage of 11 percent by volume of biodiesel and the product sold and dispensed contains less than 11 percent biodiesel by volume, no error has occurred and the product does not qualify for the credit amount available for biodiesel blended fuel that has a minimum percentage of 11 percent by volume of biodiesel.

c. *Refundability.* Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

d. *Transferability.* The credit may not be transferred to any other person.

e. *Examples.*

EXAMPLE 1: A taxpayer operated four retail motor fuel sites during 2008 and sold a combined total at all four sites of 100,000 gallons of diesel fuel, of which 55,000 gallons was biodiesel blended fuel containing a minimum percentage of 2 percent by volume of biodiesel. Because 50 percent or more of the diesel fuel sold was biodiesel blended fuel, the taxpayer may claim the biodiesel blended fuel tax credit totaling \$1,650, which is 55,000 gallons multiplied by three cents.

EXAMPLE 2: A taxpayer operated two retail motor fuel sites during 2008, and each site sold 40,000 gallons of diesel fuel. One site sold 25,000 gallons of biodiesel blended fuel containing a minimum percentage of 2 percent by volume of biodiesel, and the other site sold 10,000 gallons of biodiesel blended fuel containing a minimum percentage of 2 percent by volume of biodiesel. The taxpayer would not be eligible for the biodiesel blended fuel tax credit because only 35,000 gallons of the total 80,000 gallons, or 43.75 percent of the total diesel fuel gallons sold, was biodiesel blended fuel. The 50 percent requirement is based on the aggregate number of diesel fuel gallons sold by the taxpayer, and the fact that one retail motor fuel site met the 50 percent requirement does not allow the taxpayer to claim the biodiesel blended fuel tax credit for the 2008 tax year.

EXAMPLE 3: Same facts as in example 2, except the fuel sales occurred in 2009. The taxpayer can claim a biodiesel blended fuel tax credit totaling \$750, which is 25,000 gallons multiplied by three cents, since one of the retail motor fuel sites met the 50 percent biodiesel blended fuel requirement.

EXAMPLE 4: Same facts as in example 2, except the fuel sales occurred in 2016, and all biodiesel blended fuel sold contains a minimum percentage of 5 percent by volume of biodiesel. The taxpayer can claim a biodiesel blended fuel tax credit totaling \$1,575, which is 35,000 gallons multiplied by four and one-half cents, since the 50 percent biodiesel blended fuel requirement has been eliminated.

42.34(2) Fiscal year filers. Taxpayers whose tax year is not on a calendar-year basis and whose tax year ends before December 31, 2006, may compute the tax credit on the gallons of biodiesel blended fuel sold during the period from January 1, 2006, through the end of the tax year, provided that 50 percent of all diesel fuel sold during that period was biodiesel blended fuel. Because the tax credit is repealed on January 1, 2025, a taxpayer whose tax year ends prior to December 31, 2024, may continue to claim the tax credit in the following tax year for any biodiesel blended fuel sold through December 31, 2024.

See 701—subrule 52.31(2) for examples illustrating how this subrule is applied.

42.34(3) Allocation of credit to owners of a business entity or to beneficiaries of an estate or trust. If a taxpayer claiming the biodiesel blended fuel tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11P as amended by 2016 Iowa Acts, Senate File 2309.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9821B, IAB 11/2/11, effective 12/7/11; ARC 3043C, IAB 4/26/17, effective 5/31/17]

701—42.35(422) Soy-based transformer fluid tax credit. Effective for tax periods ending after June 30, 2006, and beginning before January 1, 2009, an electric utility may claim a soy-based transformer fluid tax credit. An electric utility, which is a public utility, city utility, or electric cooperative which furnishes electricity, may claim a credit equal to the costs incurred during the tax year for the purchase and replacement costs relating to the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.

42.35(1) Eligibility requirements for the tax credit. All of the following conditions must be met for the electric utility to qualify for the soy-based transformer fluid tax credit.

- a. The costs must be incurred after June 30, 2006, and before January 1, 2009.
- b. The costs must be incurred in the first 18 months of the transition from using nonsoy-based transformer fluid to using soy-based transformer fluid.
- c. The soy-based transformer fluid must be dielectric fluid that contains at least 98 percent soy-based products.
- d. The costs of the purchase and replacement must not exceed \$2 per gallon of soy-based transformer fluid used in the transition.
- e. The number of gallons used in the transition must not exceed 20,000 gallons per electric utility, and the total number of gallons eligible for the credit must not exceed 60,000 gallons in the aggregate.

f. The electric utility shall not deduct for Iowa income tax purposes the costs incurred in the transition to using soy-based transformer fluid which are deductible for federal income tax purposes.

42.35(2) Applying for the tax credit. An electric utility must apply to the department for the soy-based transformer fluid tax credit. The application for the tax credit must be filed no later than 30 days after the close of the tax year for which the credit is claimed. The application must include the following information:

a. A copy of the signed purchase agreement or other agreement to purchase soy-based transformer fluid.

b. The number of gallons of soy-based transformer fluid purchased during the tax year, along with the cost per gallon of each purchase made during the tax year.

c. The name, address, and tax identification number of the electric utility.

d. The type of tax for which the credit will be claimed, and the first year in which the credit will be claimed.

e. If the application is filed by a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, a list of the partners, members, shareholders or beneficiaries of the entity. This list shall include the name, address, tax identification number and pro rata share of earnings from the entity for each of the partners, members, shareholders or beneficiaries.

42.35(3) Claiming the tax credit. After the application is reviewed, the department will issue a tax credit certificate to the electric utility. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit and the tax year for which the credit may be claimed. Once the tax credit certificate is issued, the credit may be claimed only against the type of tax reflected on the certificate. If the department refuses to issue the tax credit certificate, the taxpayer shall be notified in writing; and the taxpayer will have 60 days from the date of denial to file a protest in accordance with rule 701—7.8(17A).

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on the partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

This rule is intended to implement Iowa Code section 422.11R.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—42.36(16,422) Agricultural assets transfer tax credit and custom farming contract tax credit.

42.36(1) Agricultural assets transfer tax credit. For tax years beginning on or after January 1, 2007, but before January 1, 2013, an owner of agricultural assets that rents assets to qualified beginning farmers may claim an agricultural assets transfer tax credit for Iowa individual income tax equal to 5 percent of the rental income received by the owner for cash rental agreements and 15 percent of the rental income received by the owner for commodity share agreements. Effective for tax years beginning on or after January 1, 2013, an owner of agricultural assets that rents assets to qualified beginning farmers may claim an agricultural assets transfer tax credit for Iowa individual income tax equal to 7 percent of the rental income received by the owner for cash rental agreements and 17 percent of the rental income received by the owner for commodity share agreements.

Also effective for tax years beginning on or after January 1, 2013, if the beginning farmer is a veteran, the credit is equal to 8 percent of the rental income received by the owner for cash rental agreements, and the credit is equal to 18 percent of the rental income received by the owner for commodity share agreements for the first year that the credit is allowed. However, the taxpayer may only claim 7 percent of the rental income for cash rental agreements and 17 percent of the rental income for commodity share agreements in subsequent years if the agreement is renewed or a new agreement is executed by the same parties. The administrative rules for the agricultural assets transfer tax credit for the Iowa finance authority may be found under 265—Chapter 44.

To qualify for the tax credit, an owner of agricultural assets must enter into a lease or rental agreement with a beginning farmer for a term of at least two years, but not more than five years. Both the owner of agricultural assets and the beginning farmer must meet certain qualifications set forth by the Iowa finance authority, and the beginning farmer must be eligible to receive financial assistance under Iowa Code section 16.75.

The Iowa finance authority will issue a tax credit certificate to the owner of agricultural assets which will include the name, address and tax identification number of the owner, the amount of the credit, and the tax period for which the credit may be applied. To claim the tax credit, the owner must include the tax credit certificate with the tax return for the tax period set forth on the certificate. The tax credit certificates will be issued on a first-come, first-served basis. For fiscal years beginning on or after July 1, 2009, but before July 1, 2013, the amount of tax credit certificates issued by the Iowa agricultural development authority for the agricultural assets transfer tax credit program cannot exceed \$6 million. For fiscal years beginning on or after July 1, 2013, the amount of the tax credit certificates issued by the Iowa finance authority for the agricultural assets transfer tax credit program cannot exceed \$8 million and the amount of the credit issued to an individual taxpayer cannot exceed \$50,000. However, effective December 31, 2017, the amount of tax credits issued by the Iowa finance authority for the agricultural assets transfer tax credit shall revert back to \$6 million.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. However, for any agricultural assets transfer tax credits originally issued for tax years beginning on or after January 1, 2008, any credit in excess of the tax liability may be credited to the tax liability for the following ten years. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If an owner of agricultural assets is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The lease or rental agreement may be terminated by either the owner or the beginning farmer. If the Iowa finance authority determines that the owner is not at fault for the termination, the authority will not issue a tax credit certificate for subsequent years, but any prior tax credit certificates issued will be allowed. If the Iowa finance authority determines that the owner is at fault for the termination, any prior tax credit certificates will be disallowed. The amount of tax credits previously allowed will be recaptured, and the owner will be required to repay the entire amount of tax credits previously claimed on Iowa returns.

42.36(2) Custom farming contract tax credit. Effective for tax years beginning on or after January 1, 2013, a landowner that hires a beginning farmer to custom farm agricultural land in this state may claim a custom farming contract tax credit for Iowa individual income tax. The credit is equal to 7 percent of the value of the contract. If the beginning farmer is a veteran, the credit is equal to 8 percent of the value of the contract for the first year. However, the taxpayer may only claim 7 percent of the value of the contract in subsequent years if the agreement is renewed or a new agreement is executed by the same parties. The administrative rules for the custom farming contract tax credit for the Iowa finance authority may be found under 265—Chapter 44.

To qualify for the tax credit, the taxpayer must enter into a lease or rental agreement with a beginning farmer for a term of at least two years but not more than five years. Both the taxpayer and the beginning farmer must meet certain qualifications set forth by the Iowa finance authority, and the beginning farmer must be eligible to receive financial assistance under Iowa Code section 16.75.

The Iowa finance authority will issue a tax credit certificate to the taxpayer which will include the name, address and tax identification number of the owner, the amount of the credit, and the tax period for which the credit may be applied. To claim the tax credit, the owner must include the tax credit certificate with the tax return for the tax period set forth on the certificate. For fiscal years beginning on or after July 1, 2013, the amount of tax credit certificates issued by the Iowa finance authority for the custom farming contract tax credit program cannot exceed \$4 million, and the credit certificates will be issued on

a first-come, first-served basis. The amount of the credit issued to an individual taxpayer cannot exceed \$50,000. However, effective December 31, 2017, the Iowa finance authority will no longer issue custom farming contract tax credits.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following ten years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer's estate or trust upon the death of the taxpayer.

If the party entering into the custom farming contract with the beginning farmer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The custom farming contract may be terminated by either the taxpayer or the beginning farmer. If the Iowa finance authority determines that the taxpayer is not at fault for the termination, the authority will not issue a tax credit certificate for subsequent years, but any prior tax credit certificates issued will be allowed. If the Iowa finance authority determines that the taxpayer is at fault for the termination, any prior tax credit certificates will be disallowed. The amount of tax credits previously allowed will be recaptured, and the taxpayer will be required to repay the entire amount of tax credits previously claimed on Iowa returns.

This rule is intended to implement Iowa Code section 422.11M; 2014 Iowa Acts, Senate File 2328, sections 60 and 61, as amended by 2014 Iowa Acts, House File 2454; and 2014 Iowa Acts, Senate File 2328, sections 120 and 122.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1138C, IAB 10/30/13, effective 12/4/13; ARC 1665C, IAB 10/15/14, effective 11/19/14]

701—42.37(15,422) Film qualified expenditure tax credit. Effective for tax years beginning on or after January 1, 2007, a film qualified expenditure tax credit is available for individual income tax. The tax credit cannot exceed 25 percent of the taxpayer's qualified expenditures in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film qualified expenditure tax credit for IDED may be found at 261—Chapter 36.

42.37(1) Qualified expenditures. A qualified expenditure is a payment to an Iowa resident or an Iowa-based business for the sale, rental or furnishing of tangible personal property or services directly related to the registered project. The qualified expenditures include, but are not limited to, the following:

1. Aircraft.
2. Vehicles.
3. Equipment.
4. Materials.
5. Supplies.
6. Accounting services.
7. Animals and animal care services.
8. Artistic and design services.
9. Graphics.
10. Construction.
11. Data and information services.
12. Delivery and pickup services.
13. Labor and personnel. For limitations on the amount of labor and personnel expenditures, see Iowa department of economic development 261—paragraph 36.7(2)“b.”
14. Lighting services.
15. Makeup and hairdressing services.
16. Film.
17. Music.

18. Photography.
19. Sound.
20. Video and related services.
21. Printing.
22. Research.
23. Site fees and rental.
24. Travel related to Iowa distant locations.
25. Trash removal and cleanup.
26. Wardrobe.

A detailed list of all qualified expenditures for each of these categories is available from the film office of IDEED.

42.37(2) *Claiming the tax credit.* Upon completion of the registered project in Iowa, the taxpayer must submit, in a format approved by IDEED prior to production, a listing of the qualified expenditures. Upon verification of the qualified expenditures, IDEED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit.

42.37(3) *Transfer of the film qualified expenditure tax credit.* The film qualified expenditure tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film qualified expenditure tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.37(4) *Repeal of film qualified expenditure tax credit.* The film qualified expenditure tax credit is repealed for tax years beginning on or after January 1, 2012. However, the credit is still available for tax years beginning prior to January 1, 2012, if the contract or agreement related to a film project was entered into on or before May 25, 2012.

This rule is intended to implement 2012 Iowa Acts, House File 2337, sections 38 to 40.
[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 0398C, IAB 10/17/12, effective 11/21/12; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.38(15,422) Film investment tax credit. Effective for tax years beginning on or after January 1, 2007, a film investment tax credit is available for individual income tax. The tax credit cannot exceed 25 percent of the taxpayer's investment in a film, television, or video project registered with the film office of the Iowa department of economic development (IDED). The film office may negotiate the amount of the tax credit. The administrative rules for the film investment tax credit for IDED may be found at 261—Chapter 36.

42.38(1) Claiming the tax credit. Upon completion of the project in Iowa and verification of the investment in the project, IDED will issue a tax credit certificate to the taxpayer. The certificate will list the taxpayer's name, address, and tax identification number; the date of project completion; the amount of the credit; the tax period for which the credit may be applied; and the type of tax for which the credit will be applied.

If the taxpayer is a partnership, limited liability company, S corporation, or estate or trust requesting a credit for individual or corporation income tax, the tax credit certificate will be issued to the partners, members, shareholders or beneficiaries based on each partner's, member's, shareholder's or beneficiary's pro rata share of earnings of the partnership, limited liability company, S corporation, or estate or trust.

To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate. Any tax credit in excess of the tax liability may be carried forward for five years or until the tax credit is used, whichever is the earlier. The tax credit cannot be carried back to a tax year prior to the year in which the taxpayer claimed the tax credit. In addition, a taxpayer cannot claim the film investment tax credit for qualified expenditures for which the film expenditure tax credit set forth in rule 701—42.37(15,422) is claimed.

The total of all film investment tax credits for a particular project cannot exceed 25 percent of the qualified expenditures as set forth in subrule 42.37(1) for the particular project. If the amount of investment exceeds the qualified expenditures, the tax credit will be allocated proportionately. For example, if three investors each invested \$100,000 in a project but the qualified expenditures in Iowa only totaled \$270,000, each investor would receive a tax credit based on a \$90,000 investment amount.

42.38(2) Transfer of the film investment tax credit. The film investment tax credit may be transferred no more than two times to any person or entity.

Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the film investment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate.

The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

42.38(3) Repeal of film investment tax credit. The film investment tax credit is repealed for tax years beginning on or after January 1, 2012. However, the credit is still available for tax years beginning prior

to January 1, 2012, if the contract or agreement related to a film project was entered into on or before May 25, 2012.

This rule is intended to implement 2012 Iowa Acts, House File 2337, sections 38 to 40. [ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 0398C, IAB 10/17/12, effective 11/21/12; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.39(422) Ethanol promotion tax credit. Effective for tax years beginning on or after January 1, 2009, a retail dealer of gasoline may claim an ethanol promotion tax credit. For purposes of this rule, tank wagon sales are considered retail sales. The ethanol promotion tax credit is computed on Form IA 137.

42.39(1) Definitions. The following definitions are applicable to this rule:

“Biodiesel gallonage” means the total number of gallons of biodiesel which the retail dealer sells from motor fuel pumps during a determination period. For example, 5,000 gallons of biodiesel blended fuel with a 2 percent by volume of biodiesel sold during a determination period results in a biodiesel gallonage of 100 (5,000 times 2%).

“Biofuel distribution percentage” means the sum of the retail dealer’s total ethanol gallonage plus the retail dealer’s total biodiesel gallonage expressed as a percentage of the retail dealer’s total gasoline gallonage.

“Biofuel threshold percentage” is dependent on the aggregate number of gallons of motor fuel sold by a retail dealer during a determination period, as set forth below:

Determination Period	More than 200,000 Gallons Sold by Retail Dealer	200,000 Gallons or Less Sold by Retail Dealer
2009	10%	6%
2010	11%	6%
2011	12%	10%
2012	13%	11%
2013	14%	12%
2014	15%	13%
2015	17%	14%
2016	19%	15%
2017	21%	17%
2018	23%	19%
2019	25%	21%
2020	25%	25%

“Biofuel threshold percentage disparity” means the positive percentage difference between the retail dealer’s biofuel threshold percentage and the retail dealer’s biofuel distribution percentage. For example, if a retail dealer that sells more than 200,000 gallons of motor fuel in 2009 has a biofuel distribution percentage of 8 percent, the biofuel threshold percentage disparity equals 2 percent (10% minus 2%).

“Determination period” means any 12-month period beginning on January 1 and ending on December 31.

“Ethanol gallonage” means the total number of gallons of ethanol which the retail dealer sells from motor fuel pumps during a determination period. For example, 10,000 gallons of ethanol blended gasoline formulated with a 10 percent by volume of ethanol sold during a determination period results in an ethanol gallonage of 1,000 (10,000 gallons times 10%).

“Gasoline gallonage” means the total number of gallons of gasoline sold by the retail dealer during a determination period.

42.39(2) Calculation of tax credit.

a. The tax credit is calculated by multiplying the retail dealer’s total ethanol gallonage by the tax credit rate, which is adjusted based upon the retail dealer’s biofuel threshold percentage disparity. The tax credit rate is set forth below:

Biofuel Threshold Percentage Disparity	Tax Credit Rate per Gallon 2009-2010	Tax Credit Rate per Gallon 2011	Tax Credit Rate per Gallon 2012-2020
0%	6.5 cents	8 cents	8 cents
0.01% to 2.00%	4.5 cents	6 cents	6 cents
2.01% to 4.00%	2.5 cents	2.5 cents	4 cents
4.01% or more	0 cents	0 cents	0 cents

b. For use in calculating a retail dealer's total ethanol gallonage, the department is required to establish a schedule regarding the average amount of ethanol contained in E-85 gasoline.

c. A taxpayer may claim the ethanol promotion tax credit even if the taxpayer also claims the E-85 gasoline promotion tax credit provided in rule 701—42.33(422) or the E-15 plus gasoline promotion tax credit provided in rule 701—42.46(422) for the same tax year for the same ethanol gallons.

d. The tax credit must be calculated separately for each retail motor fuel site operated by the taxpayer for tax years beginning prior to January 1, 2011. The biofuel threshold percentage disparity of the taxpayer is computed on a statewide basis based on the total ethanol gallonage sold in Iowa. The taxpayer must determine the ethanol gallonage sold at each retail motor fuel site and multiply this ethanol gallonage by the applicable tax credit rate based on the biofuel threshold percentage disparity to calculate the ethanol promotion tax credit.

e. For tax years beginning on or after January 1, 2011, the taxpayer may elect to compute the biofuel threshold percentage disparity and the tax credit on either a site-by-site basis or on a companywide basis. The election made on the first return beginning on or after January 1, 2011, for either the site-by-site method or the companywide method is binding on the taxpayer for subsequent tax years unless the taxpayer petitions the department for a change in the method. Any petition for a change in the method should be made within a reasonable period of time prior to the due date of the return for which the change is requested. For example, if a change is requested for the tax return beginning January 1, 2012, the petition should be made by January 31, 2013, which is 90 days prior to the due date of the return.

The mere fact that a change in the method will result in a larger tax credit for subsequent years is not, of itself, sufficient grounds for changing the method for computing the credit. An example of a case for which the department may grant a change in the method is if the taxpayer has a significant change in the type of fuel sold at the taxpayer's retail sites in Iowa. For example, if a retail dealer opted to start selling E-85 gasoline at all the taxpayer's retail sites in Iowa for a subsequent tax year, the department may grant a change in the method.

If a taxpayer chooses the site-by-site method to compute the biofuel threshold percentage disparity, the gallons sold at all sites in Iowa must be considered in determining if the biofuel threshold percentage as defined in subrule 42.39(1) is based on more than 200,000 gallons or on 200,000 gallons or less. For example, if a taxpayer operates three motor fuel sites in Iowa and each site sells 80,000 gallons of motor fuel during 2011, the biofuel threshold percentage of 12 percent must be used for each retail site if the tax credit is computed on a site-by-site basis, even though each retail site sold less than 200,000 gallons of motor fuel.

f. Any tax credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

42.39(3) Fiscal year filers. For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the ethanol promotion tax credit on the total ethanol gallonage sold during the year using the designated tax credit rates as shown in subrule 42.39(2), paragraph "a." Because the tax credit is repealed on January 1, 2021, a taxpayer whose tax year ends prior to December 31, 2020, may continue to claim the tax credit in the following tax year for the total ethanol gallonage sold through December 31, 2020. A taxpayer whose tax year is not on a calendar-year basis and that did not claim the ethanol promotion tax credit on the previous return may claim the tax credit for the current tax year for the period beginning on January 1 of the previous tax year until the last day of the previous tax year.

42.39(4) Allocation of tax credit to owners of a business entity. If a taxpayer claiming the ethanol promotion tax credit is a partnership, limited liability company, S corporation, estate, or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by the individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, estate, or trust.

42.39(5) Examples. The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2009 equals 100,000 gallons. This consisted of 5,000 gallons of E-85 gasoline, 80,000 gallons of E-10 (10% ethanol blended gasoline) and 15,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold at this site during 2009 15,000 gallons of diesel fuel, of which 5,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 11,950 (5,000 E-85 gallons times 79% equals 3,950; 80,000 E-10 gallons times 10% equals 8,000; and thus 3,950 plus 8,000 equals 11,950). The biodiesel gallonage sold is 100, or 5,000 times 2%. The sum of 11,950 and 100, or 12,050, is divided by the total gasoline gallonage of 100,000 to arrive at a biofuel distribution percentage of 12.05%. Since this percentage exceeds the biofuel threshold percentage of 6% for a retail dealer selling 200,000 gallons or less, the biofuel threshold disparity percentage is 0%. This calculation results in an ethanol promotion tax credit of 6.5 cents times 11,950, or \$776.75.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 5,000 gallons, or \$1,000.

EXAMPLE 2. A taxpayer that is a retail dealer of gasoline operates only one motor fuel site in Iowa. The number of gallons of gasoline sold at this site in 2010 equals 300,000 gallons which consisted of 10,000 gallons of E-85 gasoline, 230,000 gallons of E-10 (10% ethanol blended gasoline) and 60,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The taxpayer also sold 60,000 gallons of diesel fuel at this site during 2010, of which 25,000 gallons was B-2 (2% biodiesel). The ethanol gallonage is 30,900 (10,000 E-85 gallons times 79% equals 7,900; 230,000 E-10 gallons times 10% equals 23,000; and thus 7,900 plus 23,000 equals 30,900). The biodiesel gallonage sold is 500, or 25,000 times 2%. The sum of 30,900 and 500, or 31,400, is divided by the total gasoline gallonage of 300,000 to arrive at a biofuel distribution percentage of 10.47%. Since this is less than the biofuel threshold percentage of 11% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is .53%. This calculation results in an ethanol promotion tax credit of 4.5 cents times 30,900, or \$1,390.50.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or \$2,000.

EXAMPLE 3. A taxpayer that is a retail dealer of gasoline operates three motor fuel sites in Iowa during 2009, and each site sold 80,000 gallons of gasoline. Sites A and B each sold 70,000 gallons of E-10 (10% ethanol blended gasoline) and 10,000 gallons not containing ethanol. Site C sold 60,000 gallons of E-10, 10,000 gallons of E-85, and 10,000 gallons not containing ethanol. The average ethanol content of E-85 gasoline is assumed to be 79%. The retail dealer did not sell any diesel fuel at any of the motor fuel sites. The ethanol gallonage is 27,900, as shown below:

Site A – 70,000 times 10% equals	7,000
Site B – 70,000 times 10% equals	7,000
Site C – 60,000 times 10% equals	6,000
Site C – 10,000 times 79% equals	7,900
Total	<u>27,900</u>

The ethanol gallonage of 27,900 is divided by the gasoline gallonage of 240,000 to arrive at a biofuel distribution percentage of 11.63%. Since this exceeds the biofuel threshold percentage of 10% for a retail dealer selling more than 200,000 gallons, the biofuel threshold disparity percentage is 0%. The credit is computed separately for each motor fuel site, and the ethanol promotion credit equals \$1,813.50, as shown below:

Site A – 7,000 times 6.5 cents equals	\$455.00
Site B – 7,000 times 6.5 cents equals	\$455.00
Site C – 13,900 times 6.5 cents equals	\$903.50
Total	<u>\$1,813.50</u>

Since the biofuel distribution percentage and the biofuel threshold percentage disparity are computed on a statewide basis for all gallons sold in Iowa, the 6.5 cent tax credit rate is applied to the total ethanol gallonage, even if Sites A and B did not meet the biofuel threshold percentage of 10% for 2009.

In addition, the taxpayer is entitled to claim the E-85 gasoline promotion tax credit equal to 20 cents multiplied by 10,000 gallons, or \$2,000.

EXAMPLE 4. A taxpayer that is a retail dealer of gasoline has a fiscal year ending March 31, 2011, and operates one motor fuel site in Iowa. The taxpayer sold more than 200,000 gallons of gasoline during the 2010 calendar year and expects to sell more than 200,000 gallons of gasoline during the 2011 calendar year. The ethanol gallonage is 30,000 for the period from April 1, 2010, through December 31, 2010, and the ethanol gallonage is 8,000 for the period from January 1, 2011, through March 31, 2011. The biofuel distribution percentage is 11.5% for the period from April 1, 2010, through December 31, 2010, and the biofuel distribution percentage is 11.8% for the period from January 1, 2011, through March 31, 2011. This results in a biofuel threshold percentage disparity of 0% (11.0 minus 11.5) for the period from April 1, 2010, through December 31, 2010, and a biofuel threshold percentage disparity of .2% (12.0 minus 11.8) for the period from January 1, 2011, through March 31, 2011. The taxpayer is entitled to an ethanol promotion tax credit of \$2,310 for the fiscal year ending March 31, 2011, as shown below:

30,000 times 6.5 cents equals	\$1,950
8,000 times 4.5 cents equals	<u>360</u>
Total	\$2,310

EXAMPLE 5. A taxpayer that is a retail dealer of gasoline has a fiscal year ending April 30, 2009, and operates one motor fuel site in Iowa. The taxpayer expects to sell more than 200,000 gallons of gasoline during the 2009 calendar year. The ethanol gallonage is 50,000 gallons for the period from January 1, 2009, through April 30, 2009. The biofuel distribution percentage is 7.7% for the period from January 1, 2009, through April 30, 2009, which results in a biofuel threshold percentage disparity of 2.3% (10.0 minus 7.7). The taxpayer is entitled to claim an ethanol promotion tax credit of \$1,250 (50,000 gallons times 2.5 cents) on the taxpayer's Iowa income tax return for the period ending April 30, 2009.

In lieu of claiming the credit on the return for the period ending April 30, 2009, the taxpayer may claim the ethanol promotion tax credit on the tax return for the period ending April 30, 2010, including the ethanol gallonage for the period from January 1, 2009, through April 30, 2010. In this case, the taxpayer will compute the biofuel distribution percentage for the period from January 1, 2009, through December 31, 2009, to determine the proper tax credit rate to be applied to the ethanol gallonage for the period from January 1, 2009, through December 31, 2009.

EXAMPLE 6. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the companywide method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel distribution percentage is 11.63%, and since the biofuel threshold percentage is 12% for retailers selling more than 200,000 gallons of motor fuel, the biofuel threshold percentage disparity is 0.37%. This results in an ethanol promotion tax credit on a companywide basis of 6 cents multiplied by the ethanol gallonage of 27,900 or \$1,674.

EXAMPLE 7. Assume the same facts as Example 3, except that the gallons were sold in 2011. The taxpayer chose the site-by-site method to compute the biofuel threshold percentage disparity and the tax credit. The biofuel threshold percentage is still 12% since the retailer sold more than 200,000 gallons of motor fuel at all sites in Iowa. The biofuel distribution percentage for Site A and Site B is 7,000 divided by 80,000, or 8.75%. The biofuel threshold percentage disparity for Site A and Site B is 3.25%, or 12% less than 8.75%. The biofuel distribution percentage for Site C is 13,900 divided by 80,000,

or 17.38%. The biofuel threshold percentage disparity for Site C is 0% since the biofuel distribution percentage exceeds the biofuel threshold percentage. This results in an ethanol promotion tax credit on a site-by-site basis of \$1,462, as shown below:

Site A – 7,000 times 2.5 cents equals	\$175
Site B – 7,000 times 2.5 cents equals	\$175
Site C – 13,900 times 8 cents equals	\$1,112
Total	\$1,462

This rule is intended to implement Iowa Code section 422.11N as amended by 2011 Iowa Acts, Senate File 531.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9821B, IAB 11/2/11, effective 12/7/11]

701—42.40(422) Charitable conservation contribution tax credit. Effective for tax years beginning on or after January 1, 2008, a charitable conservation contribution tax credit is available for individual income tax which is equal to 50 percent of the fair market value of a qualified real property interest located in Iowa that is conveyed as an unconditional charitable donation in perpetuity by a taxpayer to a qualified organization exclusively for conservation purposes.

42.40(1) Definitions. The following definitions are applicable to this rule:

“*Conservation purpose*” means the same as defined in Section 170(h)(4) of the Internal Revenue Code, with the exception that a conveyance of land for open space for the purpose of fulfilling density requirements to obtain subdivision or building permits is not considered a conveyance for a conservation purpose.

“*Qualified organization*” means the same as defined in Section 170(h)(3) of the Internal Revenue Code.

“*Qualified real property interest*” means the same as defined in Section 170(h)(2) of the Internal Revenue Code. Conservation easements and bargain sales are examples of a qualified real property interest.

42.40(2) Computation of the credit. The credit equals 50 percent of the fair market value of the qualified real property interest. There are numerous federal revenue regulations, rulings, court cases and other provisions relating to the determination of the value of a qualified real property interest, and these are equally applicable in determining the amount of the charitable conservation contribution tax credit.

The maximum amount of the tax credit is \$100,000. The amount of the contribution for which the tax credit is claimed shall not be claimed as an itemized deduction for charitable contributions for Iowa income tax purposes.

42.40(3) Claiming the tax credit. The tax credit is claimed on Form IA 148, Tax Credits Schedule. The taxpayer must include a copy of federal Form 8283, Noncash Charitable Contributions, which reflects the calculation of the fair market value of the real property interest, with the Iowa return for the year in which the contribution is made. If a qualified appraisal of the property or other relevant information is required to be included with federal Form 8283 for federal tax purposes, the appraisal and other relevant information must also be included with the Iowa return.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following 20 years or until used, whichever is the earlier.

If the taxpayer claiming the credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual’s pro rata share of the individual’s earnings of the partnership, limited liability company, S corporation, or estate or trust.

42.40(4) Examples. The following noninclusive examples illustrate how this rule applies:

EXAMPLE 1: A taxpayer conveys a real property interest with a fair market value of \$150,000 to a qualified organization during 2008. The tax credit is equal to \$75,000, or 50 percent of the \$150,000 fair market value of the real property. The taxpayer cannot claim the \$150,000 as an itemized deduction for charitable contributions on the Iowa individual income tax return for 2008.

EXAMPLE 2: A taxpayer conveys a real property interest with a fair market value of \$500,000 to a qualified organization during 2009. The tax credit is limited to \$100,000, which equates to \$200,000 of the contribution being eligible for the tax credit. The remaining amount of \$300,000 (\$500,000 less \$200,000) can be claimed as an itemized deduction for charitable contributions on the Iowa individual income tax return for 2009.

This rule is intended to implement Iowa Code section 422.11W.
[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.41(15,422) Redevelopment tax credit. The economic development authority is authorized by the general assembly and the governor to oversee the implementation and administration of the redevelopment tax credit program. Effective for tax years beginning on or after July 1, 2009, a taxpayer whose project has been approved by the Iowa brownfield redevelopment advisory council and the economic development authority may claim a redevelopment tax credit once the taxpayer has been issued a tax credit certificate for the project by the economic development authority. The credit is based on the taxpayer's qualifying investment in a brownfield or grayfield site. The administrative rules for the economic development authority's administration of this program, including definitions of brownfield and grayfield sites, may be found in rules 261—65.11(15) and 261—65.12(15).

42.41(1) Eligibility for the credit. The economic development authority is responsible for developing a system for registration and authorization of projects receiving redevelopment tax credits. For more information, see Iowa Administrative Code 261—Chapter 65.

42.41(2) Amount of the credit.

a. Maximum credit total. For the fiscal year beginning July 1, 2009, the maximum amount of tax credits allowed is \$1 million, and the amount of credit authorized for any one redevelopment project cannot exceed \$100,000. For the fiscal year beginning July 1, 2011, the maximum amount of tax credit allowed cannot exceed \$5 million, and the amount of credit authorized for any one redevelopment project cannot exceed \$500,000. For the fiscal year beginning July 1, 2012, the maximum amount of tax credits allowed cannot exceed \$10 million, and the amount of credit authorized for any one redevelopment project cannot exceed \$1 million. For the fiscal year beginning July 1, 2013, and for each subsequent fiscal year, the maximum amount of tax credits issued by the authority shall be an amount determined by the economic development authority board but not in excess of the amount established pursuant to Iowa Code section 15.119.

b. Maximum credit per project. The maximum amount of a tax credit for a qualifying investment in any one qualifying redevelopment project shall not exceed 10 percent of the maximum amount of tax credits available in any one fiscal year pursuant to paragraph 42.41(2)“a.”

c. Percentage computation. The amount of the tax credit shall equal one of the following:

- (1) Twelve percent of the taxpayer's qualifying investment in a grayfield site.
- (2) Fifteen percent of the taxpayer's qualifying investment in a grayfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).
- (3) Twenty-four percent of the taxpayer's qualifying investment in a brownfield site.
- (4) Thirty percent of the taxpayer's qualifying investment in a brownfield site if the qualifying redevelopment project meets the requirements of green development as defined in rule 261—65.2(15).

42.41(3) Claiming the credit.

a. Certificate issuance. Upon completion of the project, the economic development authority will issue a tax credit certificate to the taxpayer. The tax credit certificate will include the taxpayer's name, address and federal identification number, the tax type for which the credit will be claimed, the amount of the credit, the tax year for which the credit may be claimed and the tax credit certificate number. In addition, the tax credit certificate will include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.41(4). To claim the tax credit, the taxpayer must include the tax credit certificate with the tax return for the tax period set forth on the certificate.

b. Pro rata share. If a taxpayer claiming the tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual

may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

c. Carryforward. Except as provided in paragraph 42.41(3) "d," any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is the earlier. The tax credit shall not be carried back to a tax year prior to the year in which the taxpayer redeems the credit.

d. Refundability. A tax credit in excess of the taxpayer's liability for the tax year is refundable if all of the conditions of economic development authority 261—paragraph 65.11(4) "b" are met.

42.41(4) Transfer of the credit. The redevelopment tax credit can be transferred to any person or entity. However, a certificate indicating that the credit is refundable is only transferrable to the extent permitted by economic development authority 261—paragraph 65.11(4) "b."

a. Submission of transferred tax credit certificate to the department—information required. Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue, along with a statement which contains the transferee's name, address and tax identification number and the amount of the tax credit being transferred, the amount of all consideration provided in exchange for the tax credit, and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the transferee shall describe the nature of nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. If the transferee is a partnership, limited liability company, S corporation, or estate or trust claiming the credit for individual or corporation income tax, the transferee shall provide a list of the partners, members, shareholders or beneficiaries and information on how the redevelopment tax credit should be divided among the partners, members, shareholders or beneficiaries. The transferee shall also provide the tax identification numbers and addresses of the partners, members, shareholders or beneficiaries.

b. Issuance of replacement certificate by the department. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue a replacement tax credit certificate to the transferee.

c. Claiming the transferred tax credit. The replacement tax credit certificate must contain the same information as that on the original tax credit certificate and must have the same effective taxable year as the original tax credit certificate. The replacement tax credit certificate may reflect a different tax type than the original tax credit certificate. The transferee may use the amount of the tax credit for any tax year for which the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit certificate shall not be included in Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes. Any consideration paid for the transfer of the tax credit certificate shall not be deducted from Iowa taxable income for individual income tax, corporation income tax, or franchise tax purposes.

42.41(5) Basis reduction of the redevelopment property. The increase in the basis of the redevelopment property that would otherwise result from the qualified redevelopment costs shall be reduced by the amount of the redevelopment tax credit. For example, if a qualifying investment in a grayfield site totaled \$100,000 for which a \$12,000 redevelopment tax credit was issued, the increase in the basis of the property would total \$88,000 for Iowa tax purposes (\$100,000 less \$12,000).

This rule is intended to implement Iowa Code sections 15.293A, 422.11V and 15.119.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9876B, IAB 11/30/11, effective 1/4/12; ARC 1102C, IAB 10/16/13, effective 11/20/13; ARC 1949C, IAB 4/1/15, effective 5/6/15]

701—42.42(15) High quality jobs program. Effective for tax periods beginning on or after July 1, 2009, a business which qualifies under the high quality jobs program is eligible to receive tax credits. The high quality jobs program replaces the high quality job creation program. An eligible business under the high quality jobs program must be approved by the Iowa department of economic development and meet the qualifications of Iowa Code section 15.329. The tax credits available under the high quality jobs program are based upon the number of jobs created or retained that pay a qualifying wage threshold and the amount of qualifying investment. The administrative rules for the high quality jobs program for the Iowa department of economic development may be found at 261—Chapter 68.

42.42(1) Research activities credit. An eligible business approved under the high quality jobs program is eligible for an additional research activities credit as described in 701—subrule 52.7(4) for awards issued by the Iowa department of economic development prior to July 1, 2010. The eligible business is eligible for the research activities credit as described in 701—subrule 52.7(6) for awards issued by the Iowa department of economic development on or after July 1, 2010.

Research activities allowable for the Iowa research activities credit include expenses related to the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa; such expenses related to the development and deployment of innovative renewable energy generation components are not eligible for the federal credit for increasing research activities. For purposes of this subrule, innovative renewable energy generation components do not include components with more than 200 megawatts in installed effective nameplate generating capacity. The research activities credit related to renewable energy generation components under the high quality jobs program and the enterprise zone program shall not exceed \$2 million for the fiscal year ending June 30, 2010, and \$1 million for the fiscal year ending June 30, 2011.

These expenses related to the development and deployment of innovative renewable energy generation components are applicable only to the additional research activities credit set forth in this subrule and in 701—subrule 52.7(5) for businesses in enterprise zones, and are not applicable to the research activities credit set forth in subrule 42.11(3), paragraphs “a” and “b.”

42.42(2) Investment tax credit. An eligible business can claim an investment tax credit equal to a percentage of the new investment directly related to new jobs created or retained by the location or expansion of an eligible business. The percentage is equal to the amount provided in Iowa department of economic development 261—subrule 68.4(7).

The determination of the new investment eligible for the investment tax credit, the eligibility of a refundable investment tax credit for value-added agricultural product or biotechnology-related projects and the repayment of investment tax credits for the high quality jobs program is the same as set forth in subrule 42.29(2) for the high quality job creation program.

42.42(3) Repayment of benefits. If an eligible business fails to maintain the requirements of the high quality jobs program, the taxpayer may be required to repay all or a portion of the tax incentives taken on Iowa returns. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the tax credits may have expired, the department may proceed to collect the tax incentives forfeited by failure of the eligible business to maintain the requirements of the high quality jobs program because the repayment is a recovery of an incentive, rather than an adjustment to the taxpayer’s tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.*, Docket No. 11DORF 042-044, June 11, 2012.

This rule is intended to implement Iowa Code chapter 15.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.43(16,422) Disaster recovery housing project tax credit. For tax years beginning on or after January 1, 2011, but before January 1, 2015, a disaster recovery housing project tax credit is available for individual income tax. The credit is equal to 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project, and is administered by the Iowa finance authority. Qualifying investments are costs incurred on or after May 12, 2009, and prior to July 1, 2010, related to a disaster recovery housing project. Eligible properties must have applied for and received an allocation of federal low-income housing tax credits under Section 42 of the Internal Revenue Code to be eligible for the tax credit. The tax credit is repealed effective January 1, 2015.

42.43(1) Issuance of tax credit certificates. Upon completion of the project and verification of the amount of investment made in the disaster recovery housing project, the Iowa finance authority will issue a tax credit certificate to the taxpayer. The tax credit certificate shall include the taxpayer's name, address, tax identification number, amount of credit, and the tax year for which the credit may be claimed. The tax credit certificates will be issued on a first-come, first-served basis. The tax credit cannot be transferred to any person or entity.

42.43(2) Limitation of tax credits. The tax credit shall not exceed 75 percent of the taxpayer's qualifying investment in a disaster recovery housing project. The maximum amount of tax credits issued by the Iowa finance authority shall not exceed \$3 million in each of the five consecutive years beginning in the 2011 calendar year. A tax credit certificate shall be issued by the Iowa finance authority for each year that the credit can be claimed.

42.43(3) Claiming the tax credit. The amount of the tax credit earned by the taxpayer will be divided by five and an amount equal thereto will be claimed on the Iowa individual income tax return commencing with the tax year beginning on or after January 1, 2011. A taxpayer is not entitled to a refund of the excess tax for any tax credit in excess of the tax liability, and also is not entitled to carry forward any excess credit to a subsequent tax year.

If the taxpayer is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

The increase in the basis of the property that would otherwise result from the disaster recovery housing investment shall be reduced by the amount of the tax credit allowed.

EXAMPLE: An individual whose tax year ends on December 31 incurs \$100,000 of costs related to an eligible disaster recovery housing project. The taxpayer receives a tax credit of \$75,000, and \$15,000 of credit can be claimed on each Iowa individual income tax return for the periods ending December 31, 2011, through December 31, 2015. If the tax liability for the individual for the period ending December 31, 2011, is \$10,000, the credit is limited to \$10,000, and the remaining \$5,000 credit cannot be used. If the tax liability for the individual for the period ending December 31, 2012, is \$25,000, the credit is limited to \$15,000, and the remaining \$5,000 credit from 2011 cannot be used to reduce the tax for 2012.

42.43(4) Potential recapture of tax credits. If the taxpayer fails to comply with the eligibility requirements of the project or violates local zoning and construction ordinances, the Iowa finance authority can void the tax credit and the department of revenue shall seek recovery of the value of any tax credit claimed on an individual income tax return.

This rule is intended to implement Iowa Code sections 16.211, 16.212 and 422.11X as amended by 2014 Iowa Acts, Senate File 2328.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 1665C, IAB 10/15/14, effective 11/19/14]

701—42.44(422) Deduction of credits.

42.44(1) Sequencing of credit deductions. The credits against computed tax set forth in Iowa Code sections 422.5, 422.8, 422.10 through 422.12C, 422.12N, and 422.110 shall be claimed in the following sequence:

- a. Personal exemption credit.
- b. Tuition and textbook credit.

- c. Volunteer fire fighter, volunteer emergency medical services personnel and reserve peace officer tax credit.
- d. Nonresident and part-year resident credit.
- e. Out-of-state tax credit.
- f. Franchise tax credit.
- g. S corporation apportionment credit.
- h. Alternative minimum tax credit (for tax years beginning during 2023 only).
- i. Historic preservation tax credit (when the taxpayer has elected that the credit be nonrefundable under Iowa Code section 404A.2(4)).
- j. School tuition organization tax credit.
- k. Innovation fund investment tax credit.
- l. Endow Iowa tax credit.
- m. Redevelopment tax credit.
- n. From farm to food donation tax credit.
- o. Workforce housing tax credit.
- p. Hoover presidential library tax credit.
- q. Enterprise zone investment tax credit.
- r. High quality jobs investment tax credit.
- s. Wind energy production tax credit.
- t. Renewable energy tax credit.
- u. New jobs tax credit.
- v. Beginning farmer tax credit.
- w. Agricultural assets transfer tax credit.
- x. Custom farming contract tax credit.
- y. Geothermal heat pump tax credit.
- z. Solar energy system tax credit.
- aa. Charitable conservation contribution tax credit.
- ab. Alternative minimum tax credit (for tax years beginning before January 1, 2023).
- ac. Historic preservation tax credit (when the taxpayer has elected that the credit be refundable under Iowa Code section 404A.2(4)).
- ad. High quality jobs third-party developer tax credit.
- ae. Research activities credit.
- af. Child and dependent care tax credit or early childhood development tax credit.
- ag. Motor fuel tax credit.
- ah. Claim of right credit (if elected in accordance with rule 701—38.18(422)).
- ai. Qualifying business investment tax credit (also known as angel investor tax credit).
- aj. Adoption tax credit.
- ak. E-85 gasoline promotion tax credit.
- al. Biodiesel blended fuel tax credit.
- am. E-15 plus gasoline promotion tax credit.
- an. Earned income tax credit.
- ao. Renewable chemical production tax credit.
- ap. Estimated payments, payment with vouchers, and withholding tax.

42.44(2) Order of credits carried forward from a previous tax year. A credit carried forward from a previous tax year shall be applied against computed tax before a credit earned under the same credit program in the current tax year. However, a credit carried forward from a previous tax year cannot be applied against computed tax before a credit earned under a different credit program in a later year that appears before it in the sequence in subrule 42.44(1). For example, a school tuition organization tax credit awarded in the current tax year must be applied against computed tax before a renewable energy tax credit carried forward from a previous tax year.

This rule is intended to implement Iowa Code sections 422.5, 422.8, 422.10, 422.11, 422.11A, 422.11B, 422.11D, 422.11E, 422.11F, 422.11H, 422.11I, 422.11J, 422.11L, 422.11M, 422.11N, 422.11O,

422.11P, 422.11Q, 422.11R, 422.11S, 422.11V, 422.11W, 422.11Y, 422.11Z, 422.12, 422.12B, 422.12C and 422.110 and 2014 Iowa Acts, House Files 2448 and 2468.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9876B, IAB 11/30/11, effective 1/4/12; ARC 0398C, IAB 10/17/12, effective 11/21/12; ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 1744C, IAB 11/26/14, effective 12/31/14; ARC 6030C, IAB 11/3/21, effective 12/8/21]

701—42.45(15) Aggregate tax credit limit for certain economic development programs. Effective for the fiscal year beginning July 1, 2009, awards made under certain economic development programs cannot exceed \$185 million during a fiscal year. Effective for fiscal years beginning on or after July 1, 2010, but beginning before July 1, 2012, awards made under these economic development programs cannot exceed \$120 million during a fiscal year. Effective for fiscal years beginning on or after July 1, 2012, awards made under these economic development programs cannot exceed \$170 million. For fiscal years beginning on or after July 1, 2010, but beginning before July 1, 2014, these programs include the assistive device tax credit program, the enterprise zone program, the housing enterprise zone program, the high quality jobs program, the redevelopment tax credit program, tax credits for investments in qualifying businesses and community-based seed capital funds, and the innovation fund tax credit program. For fiscal years beginning on or after July 1, 2014, these programs include the assistive device tax credit program, the workforce housing tax incentives program, the high quality jobs program, the redevelopment tax credit program, tax credits for investments in qualifying businesses and community-based seed capital funds, and the innovation fund tax credit program. The administrative rules for the aggregate tax credit limit for the economic development authority may be found at 261—Chapter 76.

This rule is intended to implement Iowa Code section 15.119 as amended by 2014 Iowa Acts, House File 2448.

[ARC 8702B, IAB 4/21/10, effective 5/26/10; ARC 9104B, IAB 9/22/10, effective 10/27/10; ARC 1102C, IAB 10/16/13, effective 11/20/13; ARC 1744C, IAB 11/26/14, effective 12/31/14]

701—42.46(422) E-15 plus gasoline promotion tax credit. Effective for eligible gallons sold on or after July 1, 2011, a retail dealer of gasoline may claim an E-15 plus gasoline promotion tax credit. “E-15 plus gasoline” means ethanol blended gasoline formulated with a minimum percentage of between 15 percent and 69 percent of volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. For purposes of this rule, tank wagon sales are considered retail sales. The credit is calculated on Form IA 138.

42.46(1) Calculating the credit.

a. Amount of credit. The tax credit is calculated by multiplying the total number of E-15 plus gallons sold by the retail dealer during the tax year by the following designated rates:

Gallons sold from July 1, 2011, through December 31, 2013	3 cents
Gallons sold from January 1 through May 31 and from September 16 through December 31 for the 2014-2024 calendar years	3 cents
Gallons sold from June 1 through September 15 for the 2014-2024 calendar years	10 cents

b. Claiming the credit with other credits. A taxpayer may claim the E-15 plus gasoline promotion tax credit even if the taxpayer also claims the ethanol promotion tax credit provided in rule 701—42.39(422) for gallons sold on or after January 1, 2011, but prior to January 1, 2021, for the same tax year for the same ethanol gallons.

c. Refundability. Any credit in excess of the taxpayer’s tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

d. Transferability. The credit may not be transferred to any other person.

42.46(2) Fiscal year filers. For taxpayers whose tax year is not on a calendar-year basis, the taxpayer may compute the tax credit on the gallons of E-15 plus gasoline sold during the year using the designated rates as shown above. Because the tax credit is repealed on January 1, 2025, a taxpayer whose tax year

ends prior to December 31, 2024, may continue to claim the tax credit in the following tax year for any E-15 plus gallons sold through December 31, 2024. For a retail dealer whose tax year is not on a calendar-year basis and who did not claim the E-15 plus credit on the previous return, the dealer may claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year. However, for taxpayers whose fiscal year ends prior to December 31, 2011, the dealer must claim the credit for the current tax year for gallons sold for the period beginning on July 1 of the previous tax year until the last day of the previous tax year.

EXAMPLE 1: A taxpayer who is a retail dealer of gasoline has a fiscal year ending October 31, 2011. The taxpayer sold 2,000 gallons of E-15 plus gasoline for the period from July 1, 2011, through October 31, 2011, and sold 7,000 gallons of E-15 plus gasoline for the period from November 1, 2011, through October 31, 2012. The taxpayer is entitled to a total E-15 plus gasoline promotion tax credit of \$270 for the fiscal year ending October 31, 2012, which consists of a \$60 credit (2,000 gallons multiplied by 3 cents) for the period from July 1, 2011, through October 31, 2011, and a credit of \$210 (7,000 gallons multiplied by 3 cents) for the period from November 1, 2011, through October 31, 2012.

EXAMPLE 2: A taxpayer who is a retail dealer of gasoline has a fiscal year ending April 30, 2012. The taxpayer sold 4,000 gallons of E-15 plus gasoline between July 1, 2011, and April 30, 2012. The taxpayer sold 9,000 gallons of E-15 plus gasoline between May 1, 2012, and April 30, 2013. The taxpayer is entitled to claim an E-15 plus gasoline promotion tax credit of \$120 (4,000 gallons multiplied by 3 cents) for the fiscal year ending April 30, 2012. In lieu of claiming the credit on the return for the period ending April 30, 2012, the taxpayer can claim the E-15 plus gasoline promotion tax credit on the tax return for the period ending April 30, 2013, for all E-15 plus gasoline gallons sold for the period from July 1, 2011, through April 30, 2013.

EXAMPLE 3: A taxpayer who is a retail dealer of gasoline has a fiscal year ending February 28, 2025. The taxpayer sold 20,000 total gallons of E-15 plus gasoline for the entire period from March 1, 2024, through February 28, 2025. For the period from March 1 through May 31, 2024, the taxpayer sold 4,000 gallons of E-15 plus gasoline, which entitles the taxpayer to a credit of \$120 (4,000 gallons multiplied by 3 cents). For the period from June 1 through September 15, 2024, the taxpayer sold 6,000 gallons of E-15 plus gasoline, which entitles the taxpayer to a credit of \$600 (6,000 gallons multiplied by 10 cents). For the period from September 16 through December 31, 2024, the taxpayer sold 6,000 gallons of E-15 plus gasoline, which entitles the taxpayer to a credit of \$180 (6,000 gallons multiplied by 3 cents). For the period from January 1 through February 28, 2025, the taxpayer sold 4,000 gallons of E-15 plus gasoline, which occurred after expiration of the credit. The taxpayer is entitled to claim a total E-15 plus gasoline promotion tax credit of \$900 (\$120 plus \$600 plus \$180) on the taxpayer's Iowa income tax return for the period ending February 28, 2025.

42.46(3) *Allocation of credit to owners of a business entity or to beneficiaries of an estate or trust.* If a taxpayer claiming the E-15 plus gasoline promotion tax credit is a partnership, limited liability company, S corporation, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual's pro rata share of the individual's earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement Iowa Code section 422.11Y as amended by 2016 Iowa Acts, Senate File 2309.

[ARC 9821B, IAB 11/2/11, effective 12/7/11; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 3043C, IAB 4/26/17, effective 5/31/17]

701—42.47(422) Geothermal heat pump tax credit. For tax years beginning on or after January 1, 2019, a geothermal heat pump tax credit is available for residential property located in Iowa as provided in Iowa Code section 422.12N and this rule. Information relating to Iowa geothermal tax credits available for tax years prior to January 1, 2019, can be found in prior versions of this rule. Prior versions of the Iowa Administrative Code are located here: www.legis.iowa.gov/law/administrativeRules/agencies.

42.47(1) Eligibility for the credit. To be eligible for the credit described in this rule, all of the following requirements must be met:

a. The geothermal heat pump must be eligible for the federal residential energy efficient property tax credit provided in Section 25D(a)(5) of the Internal Revenue Code.

b. The taxpayer must claim the federal residential energy efficient property tax credit provided in Section 25D(a)(5) of the Internal Revenue Code.

c. The geothermal heat pump must be installed on residential property located in Iowa and placed in service on or after January 1, 2019. In determining whether this requirement is met, the term “placed in service” has the same meaning as used in Section 25D of the Internal Revenue Code.

d. The taxpayer must submit a timely and complete application to the department in accordance with subrule 42.47(4).

42.47(2) Calculation of the credit.

a. The credit is equal to 20 percent of the federal residential energy efficient property tax credit allowed for geothermal heat pumps provided in Section 25D(a)(5) of the Internal Revenue Code. Thus, the Iowa credit rate equals the following percentage of the qualified geothermal heat pump property expenditures:

- (1) For property placed in service during calendar year 2019, 6 percent.
- (2) For property placed in service during calendar years 2020 through 2022, 5.2 percent.
- (3) For property placed in service during calendar year 2023, 4.4 percent.

b. This credit is set to expire on January 1, 2024, in accordance with Public Law No. 116-260, Div. EE, Title I, Subtitle C, §148. If the federal residential energy efficient property tax credit for geothermal heat pumps provided in Section 25D(a)(5) of the Internal Revenue Code is extended by federal legislation into additional tax years, the Iowa credit will continue to be available for each year in which the corresponding federal credit is available, absent action by the Iowa general assembly.

42.47(3) Tax credit award program limitations. No more than \$1 million in geothermal heat pump tax credits will be issued per calendar year. If the annual tax credit allocation cap is not reached, the remaining amount below the cap shall be made available for the following tax year in addition to, and cumulated with, the cap for that year.

42.47(4) How to apply for the credit—waitlist.

a. *In general.* Timely and complete applications shall be reviewed and approved on a first-come, first-served basis. Applications for the tax credit shall be submitted through the tax credit submission system, which applicants may access through the department’s website.

b. *Application deadline.* The application must be filed by May 1 of the year following the year of the installation of the geothermal heat pump.

c. *Contents of the application.* The application must contain the following information:

- (1) Name, address, and federal identification number of the taxpayer.
- (2) Date of installation of the geothermal heat pump. This is the same as the date the installation was placed in service by the taxpayer.
- (3) Copies of invoices or other documents showing the cost of the geothermal heat pump.
- (4) Amount of federal income tax credit claimed for the geothermal heat pump.
- (5) Amount of Iowa tax credit requested.
- (6) Any other information requested by the department in order to verify eligibility for or amount of the Iowa tax credit requested.

d. *Waitlist.*

(1) If the department receives applications for tax credits in excess of the annual aggregate award limitation, the department shall establish a waitlist for the next year’s allocation of tax credits. Valid and complete applications will be placed on the waitlist in the order they are received by the department. However, in the event the department denies an application or part of an application, and upon appeal by the taxpayer a previously denied tax credit amount is allowed, the date the appeal is closed will be used to determine the placement of the allowed tax credit amount on the waitlist. Waitlisted applications are reviewed and, if approved, funded in the order they are listed on the waitlist. Only valid applications filed by the taxpayer by May 1 of the year following the year the geothermal heat pump was installed shall be eligible for the waitlist.

(2) If the annual aggregate cap is reached for the final year in which the federal credit is available, no applications will be carried over to the next year. Therefore, any geothermal heat pump tax credit request related to an installation completed prior to January 1, 2024, that does not receive a tax credit award by the time the 2023 aggregate award limitation is met shall expire and shall not be carried over on the waitlist to any future year.

(3) Placement on a waitlist shall not constitute a promise binding the state that persons placed on the waitlist will actually receive the credit in a future year. The availability of a tax credit and approval of a tax credit application pursuant to this rule in a future year is contingent upon the availability of tax credits in that particular year.

42.47(5) Claiming the tax credit.

a. Certificate issuance. If the application is approved, the department will send a letter to the taxpayer including the amount of the tax credit and providing a tax credit certificate.

b. Claiming the tax credit. The geothermal heat pump tax credit will be claimed on Form IA 148, Tax Credits Schedule. The taxpayer must include with any Iowa tax return claiming the geothermal heat pump tax credit federal Form 5695, Residential Energy Credits.

c. Nonrefundable. Any credit in excess of the taxpayer's tax liability is nonrefundable.

d. Carryforward. Any tax credit in excess of the taxpayer's tax liability for the tax year may be credited to the taxpayer's tax liability for the following ten years or until depleted, whichever is earlier.

e. Nontransferable. The tax credit may not be transferred to any other person.

This rule is intended to implement Iowa Code section 422.12N and 2019 Iowa Acts, House File 779. [ARC 5589C, IAB 4/21/21, effective 5/26/21]

701—42.48(422) Solar energy system tax credit. A solar energy system tax credit is available for both residential property and business property located in Iowa as provided in Iowa Code section 422.11L and this rule.

42.48(1) Relationship between the Iowa and federal credits.

a. The Iowa credit is a percentage of the applicable federal credit. Taxpayers who apply for the Iowa credit must also qualify for and claim the corresponding federal credit. Availability of the Iowa credit for a specific type of installation in a given year is dependent upon availability of the federal credit for that type of installation.

b. The Iowa credit conforms with the Internal Revenue Code as amended to and including January 1, 2016. The term "Internal Revenue Code" as used in this rule refers to the Internal Revenue Code as it existed on January 1, 2016. See Iowa Code section 422.11L(6); see also Public Law No. 114-113, Div. P, Title III, §§ 302, 303, 304, and Div. Q, Title I, § 187.

42.48(2) Calculation of the credit—per installation award limitation.

a. The credit is equal to the sum of the following federal tax credits for property located in Iowa:

(1) Fifty percent of the federal residential energy property credit provided in Section 25D(a)(1) of the Internal Revenue Code. This federal credit equals an applicable percentage of qualified solar energy electric property expenditures described in Section 25D(d)(2) of the Internal Revenue Code for residential use. This credit is not available for Iowa purposes for any qualified solar energy electric property placed in service after December 31, 2021, in accordance with Public Law No. 114-113 Div. P, Title III, § 304.

(2) Fifty percent of the federal residential energy property credit provided in Section 25D(a)(2) of the Internal Revenue Code. This federal credit equals an applicable percentage of the qualified solar water heating property expenditures described in Section 25D(d)(1) of the Internal Revenue Code for residential use. This credit is not available for Iowa purposes for any qualified solar water heating property placed in service after December 31, 2021, in accordance with Public Law No. 114-113 Div. P, Title III, § 304.

(3) Fifty percent of the federal energy credit provided in Section 48(a)(2)(A)(i)(II) of the Internal Revenue Code. This federal credit equals an applicable percentage of energy property equipment described in Section 48(a)(3)(A)(i) of the Internal Revenue Code that uses solar energy to generate electricity, to heat or cool (or provide hot water for use in) a structure, or to provide solar process heat

(excepting property used to generate energy for the purpose of heating a swimming pool), for business use. This credit is not available for Iowa purposes for any qualified property the construction of which begins on or after January 1, 2022, in accordance with Public Law No. 114-113 Div. P, Title III, § 303.

(4) Fifty percent of the federal energy credit provided in Section 48(a)(2)(A)(i)(III) of the Internal Revenue Code. This federal credit equals an applicable percentage of energy property described in Section 48(a)(3)(A)(ii) of the Internal Revenue Code that uses solar energy to illuminate the inside of a structure using fiber-optic distributed sunlight, for business use. This credit is not available for Iowa purposes for any qualified property placed in service after December 31, 2016, in accordance with Public Law No. 114-113 Div. Q, Title I, § 187.

Iowa Solar Energy System Tax Credit Rates for Installations On or After January 1, 2016,* Based on 50% of Applicable Federal Rate Under Sections 25D and 48 of the Internal Revenue Code in Effect on January 1, 2016			
Applicable Property	Calendar Year Construction Begins	Calendar Year Property Placed in Service	Iowa Tax Credit Rate
Qualified Residential Solar Electric Property Under Section 25D(a)(1) of the Internal Revenue Code	N/A	2016-2019	15%
	N/A	2020	13%
	N/A	2021	11%
	N/A	2022 or later	0%
Qualified Residential Solar Water Heating Property Under Section 25D(a)(2) of the Internal Revenue Code	N/A	2016-2019	15%
	N/A	2020	13%
	N/A	2021	11%
	N/A	2022 or later	0%
Qualified Business Energy Property (electric, heat/cool, solar process heat) Under Section 48(a)(2)(A)(i)(II) of the Internal Revenue Code	2016-2019	2016-2023	15%
		2024 or later	5%
	2020	2020-2023	13%
		2024 or later	5%
	2021	2021-2023	11%
		2024 or later	5%
2022 or later	2022 or later	0%	
Qualified Business Energy Property (fiber-optic solar illumination) Under Section 48(a)(2)(A)(i)(III) of the Internal Revenue Code	N/A	2016	15%
	N/A	2017 or later	0%

*For a description of Iowa tax credit rates for installations placed in service prior to January 1, 2016, consult the prior versions of this rule.

b. A solar installation must be placed in service to be eligible for the tax credit. In determining whether this requirement is met, the term “placed in service” has the same meaning as used for purposes of Section 25D or 48 of the Internal Revenue Code, as applicable. The date a taxpayer begins construction of a solar installation for purposes of Section 48 of the Internal Revenue Code shall be the same date the taxpayer begins construction for Iowa purposes.

c. The amount of tax credit claimed by a taxpayer related to subparagraphs 42.48(2) “a”(1) and 42.48(2) “a”(2) cannot exceed \$5,000 per separate and distinct installation. The amount of tax credit claimed by a taxpayer related to subparagraphs 42.48(2) “a”(3) and 42.48(2) “a”(4) cannot exceed \$20,000 per separate and distinct installation. When a separate and distinct installation is used for both residential and business purposes, both award limitations apply and are calculated separately based on the proportion of the installation used for business purposes and for residential purposes. The taxpayer may use any reasonable method to establish the business and residential proportions, but the burden is on the taxpayer to prove the proper proportions. If the taxpayer does not provide adequate evidence to prove that the amounts of the business and residential proportions and the method for determining those

proportions are reasonable, and if the department is unable to determine reasonable proportions from the information provided by the taxpayer, the entire installation shall be deemed used for residential purposes. The term “separate and distinct installation” is described in subrule 42.48(5).

EXAMPLE 1: Taxpayer A is a farmer who installs solar energy property during 2020 that provides power to two farm buildings and A’s residence. Taxpayer A submits one application for the Iowa solar energy system tax credit showing \$100,000 of total eligible expenditures. Taxpayer A provides evidence to the department that adequately explains A’s method of allocating the solar energy system’s total usage between business use and personal use, and shows that 40 percent of the solar energy property is used for residential purposes and 60 percent is used for farm business purposes. The department determines the amounts and the method for determining those proportions to be reasonable and therefore considers the taxpayer to have submitted a tax credit application requesting both a residential solar energy system tax credit and a business solar energy system tax credit. The residential tax credit request includes \$40,000 ($\$100,000 \times 40\%$) of eligible expenditures, subject to the \$5,000 tax credit cap. Therefore, A is eligible for a residential tax credit of \$5,000 ($\$40,000 \times 13\%$ Iowa credit rate = \$5,200, less \$200 in excess of cap). The business tax credit request includes \$60,000 ($\$100,000 \times 60\%$) of eligible expenditures, subject to the \$20,000 tax credit cap. Therefore, A is eligible for a business tax credit of \$7,800 ($\$60,000 \times 13\%$ Iowa credit rate). Taxpayer A receives a total Iowa tax credit of \$12,800 ($\$5,000 + \$7,800$). Although A submitted one tax credit application in this situation, the resulting tax credit amount would have been the same if A had instead submitted two separate tax credit applications: one residential application with \$40,000 of eligible expenditures and one business application with \$60,000 of eligible expenditures.

EXAMPLE 2: Same facts as Example 1, except that taxpayer A does not submit adequate evidence to the department supporting a reasonable method of determining the proportion of the solar energy property used for residential and business purposes, and the department is unable to determine reasonable proportions from the information provided by A. The department deems the entire installation used for residential purposes, subject to the \$5,000 tax credit cap. Therefore, A receives a total Iowa tax credit of \$5,000 ($\$100,000 \times 13\%$ Iowa credit rate = \$13,000, less \$8,000 in excess of cap).

d. Recomputation of federal credit.

(1) Because the Iowa credit is a percentage of the applicable federal credit, when the federal credit under Section 48 of the Internal Revenue Code is recomputed under 26 CFR §1.47-1, the Iowa credit amount must also be recomputed and reduced by the same percentage that the federal credit was reduced. The federal credit recomputation is required on the federal Form 4255, Recapture of Investment Credit.

(2) In the year of the recomputation, if the amount of the Iowa credit previously claimed is less than the recomputed Iowa credit amount, the taxpayer must reduce any remaining available carryforward amount to reflect the Iowa credit carryforward remaining after the recomputation.

(3) If the amount of the Iowa credit previously claimed is more than the recomputed Iowa credit amount, the taxpayer must include the amount that was overclaimed in prior tax years as a negative credit amount on the IA 148, Iowa Tax Credit Schedule, and any remaining unused credit carryforward amount expires immediately. The negative credit amount represents the overclaimed Iowa credit and will be netted against the taxpayer’s other nonrefundable tax credits on the IA 148, Iowa Tax Credit Schedule, if any. After applying the negative credit amount against other available nonrefundable credits, if the taxpayer’s net total nonrefundable credits for the year is a negative amount, that negative amount must be entered on the appropriate line of the taxpayer’s income tax return for reporting nonrefundable Iowa credits from the IA 148, Iowa Tax Credit Schedule, and will increase the taxpayer’s tax liability.

42.48(3) Tax credit award program limitations. The following program limitations apply:

a. Aggregate tax credit award limit. No more than \$5 million of tax credits per year will be issued for calendar years beginning on or after January 1, 2015. The annual tax credit allocation cap also includes the solar energy system tax credits provided in rule 701—52.44(422) for corporation income tax and in rule 701—58.22(422) for franchise tax.

b. Allocation for residential installations. Beginning with tax year 2014, at least \$1 million of the annual tax credit allocation cap for each tax year is reserved for residential installations qualifying under Section 25D of the Internal Revenue Code. If the total amount of credits for residential installations for a

tax year is less than \$1 million, the remaining amount below \$1 million will be allowed for nonresidential installations qualifying under Section 48 of the Internal Revenue Code.

c. Rollover of unallocated credits. Beginning with calendar year 2014, if the annual tax credit allocation cap is not reached, the remaining amount below the cap shall be made available for the following tax year in addition to, and cumulated with, the cap for that year.

42.48(4) How to apply for the credit. Timely and complete applications shall be reviewed and approved on a first-come, first-served basis. Applications for the tax credit shall be submitted through the tax credit submission system, which applicants may access through the department's website.

a. Application deadline. For installations completed on or after January 1, 2014, the application must be filed by May 1 following the year of installation of the solar energy system. Notwithstanding the foregoing sentence, the following extensions are applicable to installations completed in 2014 and 2015:

(1) Solar energy systems installed during the 2014 calendar year shall be eligible for approval under Iowa Code section 422.11L even if the application is filed after May 1, 2015. Valid and complete applications shall be accepted and approved on a first-come, first-served basis and shall first be eligible for approval for the tax year during which the application is received, but not before the tax year beginning January 1, 2016.

(2) Solar energy systems installed during the 2015 calendar year shall be eligible for approval under Iowa Code section 422.11L even if the application is filed after May 1, 2016. Valid and complete applications shall be accepted and approved on a first-come, first-served basis and shall first be eligible for approval for the tax year during which the application is received, but not before the tax year beginning January 1, 2017.

b. Contents of the application. The application must contain the following information:

- (1) Name, address, and federal identification number of the taxpayer.
- (2) Date of installation of the solar energy system. This is the same as the date the installation was placed in service by the taxpayer.
- (3) The kilowatt capacity of the solar energy system.
- (4) Copies of invoices or other documents showing the cost of the solar energy system.
- (5) Amount of federal income tax credit claimed for the solar energy system.
- (6) Amount of Iowa tax credit requested.
- (7) All applicants must provide a completion sheet from a local utility company or similar documentation verifying that installation of the system has been completed. For nonresidential installations, the completion sheet must indicate the date the installation was placed in service. If a completion sheet from the local utility company or similar documentation is not available, a statement shall be provided that is similar to the one required to be attached to federal Form 3468 when claiming the federal energy credit and that specifies the date the system was placed in service.
- (8) A copy of any signed agreement made regarding the solar energy system that verifies the applicant is a qualified applicant. This includes, but is not limited to, lease agreements. When an applicant is entitled to the Iowa solar energy system tax credit for a leased solar energy system, the other party to the lease will not be entitled to such a credit for the same leased solar energy system.
- (9) For nonresidential installations, the date on which construction began.
- (10) Any other information requested by the department in order to verify eligibility for or amount of the Iowa tax credit requested.

c. Previously claimed expenditures disallowed. An applicant may not include on an application any expenditure for which the taxpayer previously received, or was denied, a tax credit award or any expenditure that was part of an approved separate and distinct installation but was disallowed due to exceeding the maximum Iowa tax credit amount.

d. Waitlist. If the department receives applications for tax credits in excess of the annual aggregate award limitation, the department shall establish a waitlist for the next year's allocation of tax credits. Valid and complete applications will be placed on the waitlist in the order they are received by the department. However, in the event the department denies an application or part of an application, and upon appeal by the taxpayer a previously denied tax credit amount is allowed, the date the appeal is

closed will be used to determine the placement of the allowed tax credit amount on the waitlist. Waitlisted applications are reviewed and, if approved, funded in the order they are listed on the waitlist. With the exception of the extension described in subparagraphs 42.48(4) “a”(1) and 42.48(4) “a”(2) above, only valid applications filed by the taxpayer by May 1 of the year following the year of the installation of the solar energy property shall be eligible for the waitlist. If the annual aggregate cap is reached for the final year in which the federal credit is available, no applications will be carried over to the next year. This tax credit limitation shall apply as follows:

(1) Residential property tax credit claims. The federal credits related to residential property under Sections 25D(a)(1) and 25D(a)(2) of the Internal Revenue Code expire and are unavailable for Iowa tax purposes for installations completed on or after January 1, 2022. Therefore, any residential tax credit request related to an installation completed prior to January 1, 2022, that does not receive a tax credit award by the time the 2021 aggregate award limitation is met shall expire and shall not be carried over on the waitlist to any future year.

(2) Business property tax credit claims. The federal credit related to business property under Section 48(a)(2)(A)(i)(II) of the Internal Revenue Code does not expire for Iowa tax purposes. It is available for installations that begin construction prior to January 1, 2022, in any future tax year the installation is placed in service. Therefore, any business tax credit request related to an installation that begins construction prior to January 1, 2022, but that does not receive a tax credit award by the time the annual aggregate award limitation is met will not expire and will be eligible to be carried over on the waitlist to future years, and receive a tax credit award in a future year, provided the authorization to approve and issue tax credits under Iowa Code section 422.11L(4) “a” is not repealed.

Placement on a waitlist shall not constitute a promise binding the state that persons placed on the waitlist will actually receive the credit in a future year. The availability of a tax credit and approval of a tax credit application pursuant to this rule in a future year is contingent upon the availability of tax credits in that particular year.

e. Certificate issuance. If the application is approved, the department will send a letter to the taxpayer including the amount of the tax credit and providing a tax credit certificate.

f. Claiming the tax credit. The solar energy system tax credit will be claimed on Form IA 148, Tax Credits Schedule. The taxpayer must include with any Iowa tax return claiming the solar energy system tax credit federal Form 5695, Residential Energy Credits, if claiming the residential energy credit or federal Form 3468, Investment Credit, if claiming the business energy credit.

g. Nonrefundable. Any credit in excess of the taxpayer’s tax liability is nonrefundable.

h. Carryforward. Any tax credit in excess of the taxpayer’s tax liability for the tax year may be credited to the taxpayer’s tax liability for the following ten years or until depleted, whichever is earlier.

i. Nontransferable. The credit may not be transferred to any other person.

42.48(5) Separate and distinct installation requirement. Only one tax credit may be awarded and claimed for each separate and distinct solar installation. Each separate and distinct installation requires a separate application. For purposes of this subrule, unless the context otherwise requires, use of the term “installation” or “solar installation” refers to the physical equipment that generates electricity using solar energy in a manner that qualifies that equipment for a tax credit. In order for an installation that otherwise meets the requirements of Iowa Code section 422.11L and this rule to be considered a separate and distinct solar installation, both of the factors in paragraphs 42.48(5) “a” and “b” must be met. This determination is made by the department and requires a review of the current application received by the department and all prior applications received by the department from any taxpayer. When determining whether a solar installation is separate and distinct from other solar installations, the department will consider the totality of the facts and circumstances surrounding the solar installations. The taxpayer bears the burden of showing that an installation qualifies as separate and distinct. For a safe harbor rule relating to solar installations that begin construction prior to June 1, 2021, see paragraph 42.48(5) “c.”

a. A repair or maintenance shall not constitute a solar installation. If the installed equipment repairs or otherwise maintains the working order of another solar installation or part of another solar installation, it will not be considered separate and distinct from that other solar installation, even if the installed equipment results in increased production capacity because of its superior quality, performance,

or efficiency, or other similar reason. Evidence that part of the other solar installation was removed or replaced at or around the time the equipment was installed is a strong indication that the equipment is a repair or maintenance, but it is not required for such a determination.

EXAMPLE 3: Taxpayer B applies for and is awarded an Iowa solar tax credit for a solar installation that powers taxpayer B's workshop. Two years after that solar installation is placed in service, the solar inverter malfunctions. Taxpayer B purchases and installs a new solar inverter, which keeps the solar installation in working order. At the same time, B also replaces several functioning solar panels on the solar installation with new, higher quality panels that increase the solar installation's production capacity. Taxpayer B submits a second application for the costs of the solar inverter and the solar panels. These costs are considered a repair or maintenance and do not qualify as separate and distinct from the prior installation. Therefore, they do not qualify for the Iowa solar tax credit. This is the result even if the costs qualify for the federal tax credit and even though the solar panels improve the productivity of the solar installation.

b. The solar installation must be a replacement installation or an independent installation.

(1) Replacement installation. When previous solar installations have been completely decommissioned, whether from disposal by the applicant or casualty loss or theft, the new solar installation may be considered a replacement installation of the decommissioned solar installation. A solar installation that ceases operation but that has not been physically removed and discarded by a person is not decommissioned unless it cannot operate and is incapable of being repaired to working order. A solar installation that merely changes location or ownership has not been decommissioned and thus may not qualify as a replacement installation. Expenditures that are subject to an insurance reimbursement do not qualify for the solar energy system tax credit.

EXAMPLE 4: Taxpayer C applies for and is awarded an Iowa solar tax credit for a solar installation that powers taxpayer C's business. One year after that solar installation is placed in service, it is destroyed beyond repair by a severe storm. Taxpayer C's insurance policy does not cover damage to a solar installation. Taxpayer C purchases and places in service another solar installation that powers taxpayer C's business and timely applies for the Iowa solar energy system tax credit. Taxpayer C's subsequent installation may be eligible for the Iowa solar energy system installation credit as a replacement installation.

(2) Independent installation. An independent installation is one that has a sufficiently remote association with other solar installations that received the Iowa solar energy system tax credit such that it can be considered independent from those other solar installations. When determining whether a particular solar installation qualifies as an independent installation, the department will first consider the electrical generation purpose of the relevant solar installations, as described in numbered paragraph 42.48(5) "b"(2)"1" below. Only if the department finds that it cannot make a determination from that criteria alone will the department consider other criteria. A nonexhaustive list of other criteria that may be considered by the department is provided in numbered paragraph 42.48(5) "b"(2)"2" below.

1. Electrical generation purpose. The department will review the electrical generation purpose of each solar installation. As described below, this involves a review of the building(s) or structure(s) being powered by each solar installation. When two or more solar installations have the same electrical generation purpose, they are not independent installations. When two or more solar installations have different electrical generation purposes, this is an indication that they may be independent installations. With respect only to a multiple housing cooperative under Iowa Code chapter 499A or a horizontal property regime under Iowa Code chapter 499B, each apartment shall constitute a building or structure, and each cooperative or regime owner's proportionate share of qualifying expenses incurred by the cooperative or regime shall constitute a solar installation paid by the cooperative or regime owner.

- Same building(s) or structure(s). If the applied-for solar installation will power buildings or structures that are also being powered by another solar installation, or that were being powered by another solar installation at some point during the 12-month period before the applied-for solar installation was placed in service, then the installations have the same electrical generation purpose. However, adequate proof from the taxpayer of a substantial increase in electricity demand is evidence tending to indicate that the solar installations do not have the same electrical generation purpose. A

“substantial increase in electricity demand” exists when the sum of the average monthly electricity consumption of each building or structure powered by the applied-for solar installation for the 12-month period before the applied-for solar installation is placed in service is at least 50 percent greater than the sum of the average monthly electricity consumption of each building or structure powered by the other solar installation for the 12-month period before the other solar installation was placed in service. Average electricity consumption shall be measured in kilowatt hours. With respect to the other solar installation, if any applicable building or structure was not in service for a period of 12 months before the other solar installation was placed in service, the average monthly electricity consumption for that building or structure shall be the average electricity consumption for the first 12 months the building or structure was in service. With respect to the applied-for solar installation, the calculation of the average monthly electricity consumption for any building or structure that was not placed in service prior to the other solar installation shall be calculated using a denominator of 12 even if that building or structure was not in service for a period of 12 months before the applied-for solar installation was placed in service. The reason for the increased electricity consumption shall not be relevant in determining if a substantial increase in electricity demand exists.

EXAMPLE 5: Taxpayer D is awarded a solar energy system tax credit for a solar installation that provides power to D’s home. Three years later, D installs a second solar installation that also provides power to D’s home. Absent additional information from D that would show a substantial increase in electricity demand, the second solar installation has the same electrical generation purpose as the first installation because they both provide power to D’s home. Therefore, the second solar installation would not be considered an independent installation.

EXAMPLE 6: Taxpayer E owns an apartment building with ten apartment units. In 2021, taxpayer E installs solar energy business property with a cost of \$300,000 that will power the apartment building. Taxpayer E submits solar tax credit applications for ten different solar installations, one for each unit within the apartment building. Each application claims \$30,000 in qualifying costs and requests an Iowa solar credit of \$3,300 ($\$30,000 \times 11\%$) for business property, for a sum total of \$33,000 in tax credits. Because the solar installations claimed on all ten applications provide power to the same apartment building, they all have the same electrical generation purpose. Therefore, only one of the solar installations could qualify for the tax credit as an independent installation, subject to the \$20,000 per-installation tax credit cap. The other nine installations would all fail to qualify as independent installations. The result is the same whether or not the apartment units have separate utility meters. See Example 10 for a different result if the building were organized as a multiple housing cooperative or horizontal property regime.

EXAMPLE 7: Taxpayer F, a machinist, is awarded a solar energy system tax credit for a solar installation that provides power to F’s machine shop. Several years later, F installs a second solar installation that will provide power to F’s machine shop but also to F’s office building. Taxpayer F submits a complete and timely application for the solar energy system tax credit. Absent additional information from F that would show a substantial increase in electricity demand, the second solar installation has the same electrical generation purpose as the first solar installation because they both provide power to F’s machine shop. Therefore, the second solar installation would not be considered an independent installation.

EXAMPLE 8: Assume the same facts as Example 7, except that taxpayer F provides additional information to the department regarding the electricity consumption of F’s machine shop and office building. Taxpayer F provides utility bills which show that for the 12-month period before the first solar installation was placed in service, the average monthly electricity consumption for the machine shop was 1,000 kilowatt hours. For the 12-month period before the second solar installation was placed in service, the average monthly electricity consumption for the machine shop was 1,200 kilowatt hours. Additionally, the office building was constructed and placed in service three months before the second solar installation was placed in service. Taxpayer F provides utility bills which show that for the three months the office building was in service, the monthly electricity consumption for the office building was 1,400 kilowatt hours, 1,600 kilowatt hours, and 1,800 kilowatt hours, respectively. This means that the average monthly electricity consumption of the office building for purposes of

the “substantial increase in energy demand” test is 400 kilowatt hours [i.e., $(1,400 + 1,600 + 1,800) \div 12 = 400$]. Therefore, for the 12-month period before the second solar installation was placed in service, the average monthly electricity consumption for the machine shop and office building was 1,600 kilowatt hours [i.e., $1,200 + 400 = 1,600$]. Because this 1,600 monthly kilowatt hour average applicable to the second solar installation exceeds by at least 50 percent the 1,000 monthly kilowatt hour average applicable to the first solar installation, taxpayer F has shown a substantial increase in electricity demand and the second solar installation may qualify as an independent installation.

- Different building(s) or structure(s). If the applied-for solar installation will not power any building or structure that is also being powered by another solar installation, or that was also being powered by another solar installation at some point during the 12-month period before the applied-for solar installation was placed in service, this is an indication that the solar installations may have a different electrical generation purpose.

EXAMPLE 9: Taxpayer G, a farmer, is awarded a solar energy system tax credit for a solar installation that provides power to G’s equipment barn. Later, G installs a second solar installation that will only provide power to G’s livestock building. Because the first solar installation only provides power to G’s barn and the second solar installation only provides power to G’s livestock building, this is an indication that each solar installation has a different electrical generation purpose. The second solar installation would be considered an independent installation, unless additional information shows the contrary to be true.

EXAMPLE 10: Taxpayer H, a multiple housing cooperative under Iowa Code chapter 499A, owns an apartment building with ten apartment units. In 2021, H installs solar energy property with a cost of \$300,000 that will power the apartment building. The owner of each apartment unit submits a solar tax credit application for a solar installation claiming a proportionate share of H’s qualifying expenditures for the solar energy property, which in this case is \$30,000 per owner, and requesting an Iowa credit of \$3,300 ($\$30,000 \times 11\%$), for a sum total of \$33,000 in tax credits. Since this building is organized as a multiple housing cooperative under Iowa Code chapter 499A, each apartment constitutes a building or structure and each owner’s proportionate share of qualifying expenses incurred by the cooperative constitutes a solar installation paid by the owner. This is the first solar installation with respect to each of these apartments, so they are not being powered by another solar installation that received an Iowa tax credit. Therefore, this is an indication that each solar installation has a different electrical generation purpose. Each of the ten solar installations would be considered an independent installation, unless additional information shows the contrary to be true. The result would be the same if the building were organized as a horizontal property regime under Iowa Code chapter 499B. However, see Example 7 regarding apartment buildings not organized as a multiple housing cooperative or horizontal property regime.

2. Other criteria.

- Location. The department will consider the physical location of each solar installation. When two or more solar installations are in close physical proximity, this is an indication that the installations may not be independent installations. The farther in physical proximity the installations are, the stronger the likelihood that they are independent installations. Locating an installation at the same address or on the same or adjacent parcel as another installation is a stronger indication that the two installations are not independent installations than if they were located at different addresses or on nonadjacent parcels. The expansion in physical size or production capacity of an existing solar installation is an indication that the installations are not independent installations. If two or more solar installations are physically attached or connected to the same building or structure, this is an indication that the installations are not independent installations.

EXAMPLE 11: Taxpayer Q submits a complete and timely solar energy system tax credit application for a solar installation located at an address that is adjacent to the address of a prior solar installation for which taxpayer Q received a solar energy system tax credit award. Based on the information provided by the taxpayer, the department is unable to determine the electrical generation purpose of the solar installations. Without additional information, the proximity of the two solar installations supports a determination by the department that the second solar installation is not an independent installation.

- **Billing.** The department will consider the manner in which a utility company issues bills associated with solar installations. Even when a solar installation does not actually provide electricity to any buildings or structures that are also being powered by another solar installation, if a utility company issues bills associated with a solar installation under a net metering agreement in a manner that allows credits from the net outflow of one solar installation to be applied against the utility costs of buildings or structures that are powered by another solar installation, the department will evaluate the solar installations subject to the net metering agreement as if they were powering the same buildings or structures for purposes of determining electrical generation purpose in numbered paragraph 42.48(5) “b”(2)“1” above.

- **Utility metering.** The department will consider whether each solar installation is connected to a separate utility meter and the business reason, if any, for using separate utility meters. For purposes of this subrule, “utility meter” means a device installed by a utility company used to monitor the amount of electricity consumed or produced by a consumer. When a metering agreement requires a person to install two unidirectional meters, the set will be considered a single utility meter for purposes of this subrule. The department will not consider a measuring device installed and used by a person for personal monitoring of electricity production or consumption to be a “utility meter” for purposes of this subrule. This should not be interpreted to require a person to connect the person’s solar installation to a utility provider’s grid in order to be eligible for the tax credit.

- **Payment for installation or service.** The department will consider how expenses incurred for construction or servicing of a solar installation are paid. When expenses incurred for two or more solar installations are paid by related parties, it may indicate that the installations are not independent installations. However, the department may request additional information to evaluate the relationship between the person who pays for such expenses and the person who claims the tax credit.

- **Contract terms.** The department will consider the terms of installation and service contracts related to the solar installation and may require a person to provide installation and service contracts related to any prior solar installation for which the department has received a tax credit application. When contract terms indicate that the solar installations have been installed as or are serviced as a single, functional unit or system, the department will consider that as evidence that the installations are not independent installations.

- **Timing of installation or application.** The department will consider when the applied-for solar installation was placed in service and when a person submits the tax credit application as compared to other solar installations.

c. **Safe harbor for solar installations that begin construction prior to June 1, 2021.** For any solar installation for which the taxpayer begins construction prior to June 1, 2021, the taxpayer may rely on the factors in the prior version of paragraph 42.48(7) “a” in determining whether the solar installation is a separate and distinct installation. Prior versions of the Iowa Administrative Code are located here: www.legis.iowa.gov/law/administrativeRules/agencies.

42.48(6) *Unavailable to those eligible for renewable energy tax credit.* A taxpayer who is eligible to receive a renewable energy tax credit provided in rule 701—42.28(422,476C) is not eligible for the solar energy system tax credit.

42.48(7) *Allocation of tax credit to owners of a business entity or beneficiaries of an estate or trust.* If the taxpayer claiming the tax credit based on a percentage of the federal energy credit under Section 48 of the Internal Revenue Code is a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual, the individual may claim the tax credit. The amount claimed by the individual shall be based upon the pro rata share of the individual’s earnings of the partnership, limited liability company, S corporation, estate, or trust. The maximum amount of credit available to a partnership, limited liability company, S corporation, estate, or trust shall be limited to \$15,000 for installations placed in service in tax years 2012 and 2013 and \$20,000 for installations placed in service in tax years beginning on or after January 1, 2014.

This rule is intended to implement Iowa Code section 422.11L.

[ARC 0361C, IAB 10/3/12, effective 11/7/12; ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 1666C, IAB 10/15/14, effective 11/19/14; ARC 2925C, IAB 2/1/17, effective 3/8/17; ARC 5590C, IAB 4/21/21, effective 5/26/21]

701—42.49(422) Volunteer fire fighter, volunteer emergency medical services personnel member, and reserve peace officer tax credit. Effective for tax years beginning on or after January 1, 2014, a tax credit is available for individual income tax for volunteer fire fighters, volunteer emergency medical services (EMS) personnel members, and reserve peace officers.

42.49(1) Definitions. The following definitions are applicable to this rule:

“*Emergency medical services personnel member*” or “*EMS personnel member*” means an emergency medical care provider, as defined in Iowa Code section 147A.1, who is certified as a first responder in accordance with Iowa Code chapter 147A. For tax years beginning on or after January 1, 2014, “emergency medical services personnel member” or “EMS personnel member” also includes an individual who is a paid employee of an emergency medical services program and who is also a volunteer emergency medical services personnel member in a city, county, or area governed by an agreement pursuant to Iowa Code chapter 28E.

“*Reserve peace officer*” means a reserve peace officer as defined in Iowa Code section 80D.1A who has met the minimum state training standards established by the Iowa law enforcement academy in accordance with Iowa Code chapter 80D.

“*Volunteer fire fighter*” means a volunteer fire fighter, as defined in Iowa Code section 85.61, who has met the minimum training standards established by the fire service training bureau pursuant to Iowa Code chapter 100B. For tax years beginning on or after January 1, 2014, “volunteer fire fighter” means an individual who is an active member of an organized volunteer fire department in Iowa or is performing services as a volunteer fire fighter for a municipality, township, or benefited fire district at the request of the chief or other person in command and who has met the minimum training standards established by the fire service training bureau pursuant to Iowa Code chapter 100B. For tax years beginning on or after January 1, 2014, a volunteer fire fighter also includes an individual who is a paid employee of a fire department and who is also a volunteer fire fighter in a city, county, or area governed by an agreement pursuant to Iowa Code chapter 28E.

42.49(2) Calculation of the credit.

a. The credit is equal to \$250 for tax years beginning on or after January 1, 2021, if the volunteer fire fighter, volunteer EMS personnel member, or reserve peace officer was a volunteer for the entire year. The credit is equal to \$50 for tax year 2013 and \$100 for tax years 2014 through 2020.

b. If the individual was not a volunteer fire fighter, volunteer EMS personnel member, or reserve peace officer for the entire calendar year, the credit is prorated based on the number of months the individual was a volunteer. If the individual was a volunteer during any part of a month, the individual will be considered a volunteer for the entire month. The amount of credit will be rounded to the nearest dollar.

EXAMPLE: An individual became a volunteer fire fighter on April 15, 2021, and remained a volunteer for the rest of calendar year 2021. The individual is considered a volunteer for nine months of 2021. The tax credit for 2021 is equal to \$188 (\$250 multiplied by 9/12 equals \$187.50; rounding to the nearest dollar results in a \$188 credit).

c. If an individual holds more than one volunteer position as a volunteer fire fighter, a volunteer EMS personnel member, or a reserve peace officer during the same month, a credit can be claimed for only one volunteer position for that month. For example, if an individual was both a volunteer fire fighter and volunteer EMS personnel member for all of calendar year 2021, the tax credit will equal \$250.

42.49(3) Verification of eligibility for the tax credit. An individual is required to have a written statement from the fire chief or other appropriate supervisor verifying that the individual was a volunteer fire fighter or volunteer EMS personnel member for the months for which the tax credit is being claimed. An individual who is a reserve peace officer must have a written statement from the chief of police, sheriff, commissioner of public safety, or other appropriate supervisor verifying that the individual was a reserve peace officer for the months for which the tax credit is being claimed. The written statement

does not have to be attached to a tax return claiming the credit. However, the department may request that the individual provide the written statement.

This rule is intended to implement Iowa Code section 422.12.

[ARC 0398C, IAB 10/17/12, effective 11/21/12; ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 6227C, IAB 3/9/22, effective 4/13/22]

701—42.50(422) Taxpayers trust fund tax credit. For tax years beginning on or after January 1, 2013, a taxpayers trust fund tax credit is available for Iowa individual income tax. The credit is available for all individual income tax filers, including residents, nonresidents and part-year residents of Iowa, and individuals who file as part of a composite return as described in rule 701—48.1(422), as long as the Iowa return is filed within the extended due date to file an Iowa return. Therefore, a fiscal-year filer whose tax year does not begin on January 1 is eligible to claim the taxpayers trust fund tax credit as long as the return is filed within the extended due date of the Iowa return.

42.50(1) Calculation of the amount of tax credit. The credit is calculated by taking the amount in the Iowa taxpayers trust fund and dividing it by the number of individual income taxpayers who filed Iowa returns by October 31 of the year preceding the year in which the credit is allowed.

EXAMPLE: There is \$120 million in the Iowa taxpayers trust fund at the end of the fiscal year ending June 30, 2013. There were 2,200,000 individuals who filed Iowa income tax returns by October 31, 2013, for tax years beginning on or after January 1, 2012, but beginning before January 1, 2013. This results in an Iowa taxpayers trust fund tax credit of \$54 for the tax year beginning on or after January 1, 2013, but beginning before January 1, 2014 (\$120,000,000 divided by 2,200,000 equals \$54.55, which is rounded down to the nearest whole dollar). All taxpayers who file their Iowa individual income tax return by October 31, 2014, for the tax period beginning on or after January 1, 2013, but beginning before January 1, 2014, will be entitled to claim a \$54 Iowa taxpayers trust fund tax credit.

If the amount of Iowa taxpayers trust fund tax credits claimed on tax returns for a particular year is less than the amount authorized, the difference will be transferred to the Iowa taxpayers trust fund for the next year and will be available as an Iowa taxpayers trust fund tax credit for the next year. There must be a balance in the Iowa taxpayers trust fund of at least \$30 million in order for the Iowa taxpayers trust fund tax credit to be available.

EXAMPLE: There is \$120 million in the Iowa taxpayers trust fund at the end of the fiscal year ending June 30, 2013. The total amount of Iowa taxpayers trust fund tax credit claimed on Iowa tax returns for tax years beginning on or after January 1, 2013, but beginning before January 1, 2014, which were filed on or before October 31, 2014, is \$90 million. The difference of \$30 million will be transferred to the Iowa taxpayers trust fund for the fiscal year ending June 30, 2014. The legislature approves an additional \$60 million to be deposited in the Iowa taxpayers trust fund for the fiscal year ending June 30, 2014. This will result in \$90 million in the Iowa taxpayers trust fund for the fiscal year ending June 30, 2014. If 2,200,000 individuals file Iowa individual income tax returns for tax years beginning on or after January 1, 2013, but beginning before January 1, 2014, by October 31, 2014, this will result in a \$40 Iowa taxpayers trust fund tax credit for the tax year beginning on or after January 1, 2014, but beginning before January 1, 2015 (\$90,000,000 divided by 2,200,000 equals \$40.90, which is rounded down to the nearest whole dollar).

42.50(2) Claiming the credit on the tax return. The Iowa taxpayers trust fund is claimed on the amount of Iowa tax computed after all other nonrefundable credits allowed in division II of Iowa Code chapter 422 (excluding the Iowa taxpayers trust fund tax credit) are deducted, after the amount of school district surtax described in rule 701—42.1(257,422) and emergency medical services income surtax described in rule 701—42.2(422D) is added, and after all refundable credits (excluding estimated payments and tax withheld) allowed in division II of Iowa Code chapter 422 are deducted. Any Iowa taxpayers trust fund tax credit in excess of the tax liability is not refundable and shall not be carried back to the tax year prior to the tax year in which the credit is claimed and cannot be carried forward to a tax year for any following year.

EXAMPLE: A taxpayer reported a tax liability of \$100 on the taxpayer's 2013 Iowa income tax return. The taxpayer claimed a \$40 personal exemption credit and a \$25 franchise tax credit. This resulted in

tax due of \$35 before applying the school district surtax. Taxpayer was subject to a \$2 school district surtax which resulted in total tax due of \$37. Taxpayer was entitled to claim a \$54 Iowa taxpayers trust fund tax credit, but only \$37 of credit could be applied on the 2013 Iowa return. The remaining \$17 of credit cannot be refunded, cannot be applied to a prior year tax liability, and cannot be carried forward to be applied to a subsequent year tax liability.

This rule is intended to implement Iowa Code section 422.11E.
[ARC 1102C, IAB 10/16/13, effective 11/20/13; ARC 1665C, IAB 10/15/14, effective 11/19/14]

701—42.51(422,85GA,SF452) From farm to food donation tax credit. Effective for tax years beginning on or after January 1, 2014, a taxpayer that donates a food commodity that the taxpayer produces may claim a tax credit for Iowa individual income tax. The credit is equal to 15 percent of the value of the commodities donated during the tax year for which the credit is claimed or \$5,000, whichever is less. The value of the commodities shall be determined in the same manner as a charitable contribution of food for federal tax purposes under Section 170(e)(3)(C) of the Internal Revenue Code.

To qualify for the tax credit, the taxpayer (1) must produce the donated food commodity; (2) must transfer title to the donated food commodity to an Iowa food bank or Iowa emergency feeding organization recognized by the department; and (3) shall not receive remuneration for the transfer. The donated food commodity cannot be damaged or out-of-condition and declared to be unfit for human consumption by a federal, state, or local health official. A food commodity that meets the requirements for donated foods pursuant to the federal Emergency Food Assistance Program satisfies this requirement.

To be recognized by the department, a food bank or emergency feeding organization must either be a recognized affiliate of one of the eight partner food banks with the Iowa Food Bank Association or must register with the department. To register with the department, the organization must meet the definition of “emergency feeding organization,” “food bank,” or “food pantry” as defined by the department of human services in 441—66.1(234). The department of revenue will make registration forms available on the department’s website. The department will maintain a list of recognized organizations on the department’s website.

Food banks and emergency feeding organizations that receive eligible donations shall be required to issue receipts in a format prescribed by the department for all donations received and must annually submit to the department a receipt log of all the receipts issued during the tax year. The receipt log must be submitted in the form of a spreadsheet with column specifications as provided by the department. Receipt logs showing the donations for the previous calendar year must be delivered electronically or mailed to the department postmarked by January 15 of each year. If a receipt for a taxpayer’s claim is not provided by the organization, the taxpayer’s claim will be denied.

To claim the credit, a taxpayer shall submit to the department the original receipts that were issued by the food bank or emergency feeding organization. The receipt must include quantity information completed by the food bank or emergency feeding organization, taxpayer information, and a donation valuation consistent with Section 170(e)(3)(C) of the Internal Revenue Code completed by the taxpayer. Claims must be postmarked on or before January 15 of the year following the tax year for which the claim is requested. Once the department verifies the amount of the tax credit, a letter will be sent to the taxpayer providing the amount of the tax credit and a tax credit certificate number.

Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following five years or until used, whichever is earlier. The tax credit shall not be carried back to a tax year prior to the year in which the owner redeems the credit. The credit is not transferable to any other person other than the taxpayer’s estate or trust upon the death of the taxpayer.

If the producer is a partnership, limited liability company, S corporation, estate or trust electing to have the income taxed directly to the individual, an individual may claim the credit. The amount claimed by an individual must be based on the individual’s pro rata share of the individual’s earnings of the partnership, limited liability company, S corporation, or estate or trust.

This rule is intended to implement 2013 Iowa Acts, Senate File 452, division XVIII.
[ARC 1138C, IAB 10/30/13, effective 12/4/13]

701—42.52(422) Adoption tax credit. Effective for tax years beginning on or after January 1, 2014, an adoption tax credit is available for individual income tax equal to the amount of qualified adoption expenses paid or incurred by a taxpayer related to the adoption of a child. For an adoption finalized on or after January 1, 2014, but before January 1, 2017, the total adoption tax credit claimed for the adoption may not exceed \$2,500. For an adoption finalized on or after January 1, 2017, the total adoption tax credit claimed for the adoption may not exceed \$5,000.

42.52(1) Adoption. For purposes of the credit, an adoption occurs when a child is permanently placed in Iowa by any of the following:

- a. The department of human services;
- b. An adoption service provider as defined in Iowa Code section 600A.2; or
- c. An agency that meets the provisions of the interstate compact in Iowa Code section 232.158.

42.52(2) Child. A “child” is an individual who is under the age of 18 years. “Child” does not include any individual who is 18 years of age or older.

42.52(3) Qualified adoption expenses.

a. *Generally.* “Qualified adoption expenses” means unreimbursed expenses paid or incurred in connection with the adoption of a child. Qualified adoption expenses include all fees and costs related to the adoption of a child, such as:

- (1) Medical and hospital expenses of the biological mother that are incident to the child’s birth;
- (2) Welfare agency fees and other reasonable and necessary adoption fees;
- (3) Court costs, attorney fees, and other legal fees;
- (4) Travel expenses, including amounts spent for meals and lodging while away from home; and
- (5) All other fees and costs related to the adoption of a child.

b. *Limitations.* Expenses that are eligible for the federal adoption credit as provided in Section 23(d)(1) of the Internal Revenue Code will be considered qualified adoption expenses. Expenses paid or incurred in violation of state or federal law are not qualified adoption expenses. Expenses that have been reimbursed are not qualified adoption expenses.

42.52(4) Claiming the credit.

a. *Amount eligible for credit.* For tax years beginning on or after January 1, 2014, but beginning before January 1, 2017, the first \$2,500 of qualified adoption expenses is eligible for the credit. For tax years beginning on or after January 1, 2017, the first \$5,000 of qualified adoption expenses is eligible for the credit. The maximum credit amount is determined at the time the adoption becomes final. If the qualified adoption expenses are less than the maximum credit amount, then the total amount of qualified expenses can be claimed as a credit. The amount of tax credit claimed cannot be used as an itemized deduction for adoption expenses provided in 701—subrule 41.5(3).

b. *Claiming the credit in tax years beginning on or after January 1, 2014, but before January 1, 2019.*

(1) Claiming the credit in the year the adoption becomes final. For tax years beginning on or after January 1, 2014, but before January 1, 2019, to claim an adoption tax credit, a taxpayer must claim the credit for all qualified adoption expenses paid or incurred in the tax year the adoption becomes final, up to the maximum credit amount provided in paragraph 42.52(4) “a.”

EXAMPLE: Michael and Lori are married. Michael and Lori adopt a child who is permanently placed in Iowa. The adoption process begins and becomes final in 2015. Because the adoption becomes final on or after January 1, 2014, but prior to January 1, 2017, Michael and Lori qualify for a maximum credit amount of \$2,500. Michael and Lori incur and pay unreimbursed qualified adoption expenses of \$20,000 in 2015. Michael and Lori jointly file their Iowa individual income tax return in 2015. Michael and Lori may claim an Iowa adoption tax credit of \$2,500 in 2015.

(2) Claiming the credit in years other than the year the adoption becomes final. For tax years beginning on or after January 1, 2014, but before January 1, 2019, if a taxpayer cannot claim the maximum credit amount provided in paragraph 42.52(4) “a” for the year the adoption becomes final, the taxpayer may amend a prior year’s return to claim any remaining credit for expenses paid in that prior year, or the taxpayer may claim any remaining credit on a subsequent year’s return for expenses paid in that subsequent year. If a qualified adoption expense was incurred in one tax year and paid in

another tax year, the taxpayer may only claim a credit for that expense in one year. The total adoption tax credit claimed for all years combined may not exceed the maximum credit amount per adoption provided in paragraph 42.52(4)“a.” An adjustment to a prior’s year return is subject to the limitations in rule 701—40.20(422).

EXAMPLE: Erin adopts a child as a single parent. The child is permanently placed in Iowa. The adoption process begins in 2016 and becomes final in 2017. Because the adoption becomes final on or after January 1, 2017, Erin qualifies for a maximum credit amount of \$5,000. Erin pays and incurs unreimbursed qualified adoption expenses of \$20,000 in 2016 and \$1,000 in 2017. In tax year 2017, Erin may claim an Iowa adoption tax credit equal to the \$1,000 in unreimbursed qualified adoption expenses paid and incurred in 2017. After claiming the credit for tax year 2017, Erin may amend the 2016 return to claim the remaining \$4,000 credit for unreimbursed qualified adoption expenses paid and incurred in 2016.

c. Claiming the credit in tax years beginning on or after January 1, 2019.

(1) Claiming the credit in the year the adoption becomes final. For tax years beginning on or after January 1, 2019, to claim an adoption tax credit, a taxpayer must claim the credit in the tax year the adoption is finalized for all qualified adoption expenses paid or incurred prior to or in the tax year the adoption becomes final, up to the maximum credit amount of \$5,000. A taxpayer shall not amend a prior year return in an attempt to claim the credit for unreimbursed qualified adoption expenses paid or incurred prior to the tax year in which the adoption becomes final.

EXAMPLE: Y and Z are married. Y and Z adopt a child who is permanently placed in Iowa. The adoption process begins in 2016 and becomes final in 2019. Because the adoption becomes final on or after January 1, 2017, Y and Z qualify for a maximum credit amount of \$5,000. Additionally, because the adoption becomes final on or after January 1, 2019, Y and Z may claim an Iowa adoption tax credit for unreimbursed qualified adoption expenses paid or incurred prior to or in the year the adoption becomes final. Y and Z incur and pay unreimbursed qualified adoption expenses of \$5,000 in 2016, \$10,000 in 2017, \$2,000 in 2018, and \$2,000 in 2019. Y and Z jointly file their Iowa individual income tax return in 2019. Y and Z may claim an Iowa adoption tax credit of \$5,000 on their 2019 Iowa income tax return. Y and Z are not allowed to amend a prior year return in an attempt to claim the credit for unreimbursed qualified adoption expenses paid or incurred prior to the tax year in which the adoption became final.

(2) Claiming the credit in years after the adoption becomes final. For tax years beginning on or after January 1, 2019, if a taxpayer cannot claim the maximum credit amount of \$5,000 for the year the adoption becomes final, the taxpayer may claim an adoption tax credit for any unreimbursed qualified adoption expenses paid or incurred after the tax year in which the adoption becomes final in the tax year in which unreimbursed qualified adoption expenses are paid or incurred.

EXAMPLE: W and X are married. W and X adopt a child who is permanently placed in Iowa. The adoption process begins in 2018 and becomes final in 2019. Because the adoption becomes final on or after January 1, 2017, W and X qualify for a maximum credit amount of \$5,000. W and X incur and pay unreimbursed qualified adoption expenses of \$1,000 in 2018, and \$1,000 in 2019. W and X jointly file their Iowa individual income tax return in 2019. W and X may claim the Iowa adoption tax credit in 2019 in the amount of \$2,000. In 2020, W and X incur and pay \$5,000 in unreimbursed qualified adoption expenses in connection to the adoption finalized in 2019. W and X may claim the remaining \$3,000 credit on their jointly filed Iowa individual income tax return for 2020 for unreimbursed qualified adoption expenses incurred and paid in 2020. W and X shall not amend their 2019 return to reflect the additional unreimbursed qualified adoption expenses from 2020.

d. Claiming the credit by two adoptive parents. The adoption tax credit may only be claimed by a person who adopted the child. When a married couple adopts a child together and the couple files jointly on the same return, the credit may only be claimed once between the couple. When any other two persons adopt a child together, including married persons filing separately on the same or different returns or any unmarried persons filing on separate returns, the credit must be divided between the adoptive parents. Two adoptive parents, other than persons who are married filing jointly, may agree to divide the credit in any way. The total adoption tax credit claimed for all years by both parents combined may not exceed the maximum credit amount per adoption provided in paragraph 42.52(4)“a.”

EXAMPLE: Peyton and Kerry are unmarried individuals. Peyton and Kerry adopt a child together. The child is permanently placed in Iowa. The adoption process begins and ends in 2018. Because the adoption becomes final on or after January 1, 2017, Peyton and Kerry qualify for a maximum credit amount of \$5,000. However, Peyton and Kerry pay and incur unreimbursed qualified adoption expenses of only \$3,000 in 2018. Accordingly, Peyton and Kerry may claim an Iowa adoption tax credit of \$3,000 in 2018, which must be divided between them. Peyton and Kerry agree that Peyton will claim \$2,000 of the credit, and Kerry will claim \$1,000 of the credit.

e. Adoption of a special needs child. If a taxpayer adopts a special needs child, the credit under this rule cannot exceed the amount of qualified adoption expenses paid or incurred by the taxpayer during the tax year. The amount of the federal adoption tax credit claimed for the adoption of a special needs child does not affect the amount of the credit under this rule.

EXAMPLE: Francis and Mandy are married. Francis and Mandy adopt a special needs child who is permanently placed in Iowa. The adoption process begins and ends in 2017. Francis and Mandy paid and incurred \$2,000 in unreimbursed qualified adoption expenses related to the adoption during 2017. For federal purposes, Francis and Mandy qualify for a maximum adoption tax credit of \$13,570 for the adoption of a special needs child. For Iowa purposes, Francis and Mandy qualify for a maximum adoption tax credit of \$2,000, which is equal to the amount of unreimbursed qualified adoption expenses they paid or incurred related to the adoption during the tax year.

f. Adoption tax credit in excess of tax liability. Any credit in excess of the taxpayer's tax liability is refundable. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year.

This rule is intended to implement Iowa Code section 422.12A as amended by 2016 Iowa Acts, House File 2468; 2017 Iowa Acts, Senate File 433; and 2019 Iowa Acts, House File 779. [ARC 1665C, IAB 10/15/14, effective 11/19/14; ARC 3749C, IAB 4/11/18, effective 5/16/18; ARC 5308C, IAB 12/2/20, effective 1/6/21]

701—42.53(15) Workforce housing tax incentives program. A business which qualifies under the workforce housing tax incentives program is eligible to receive tax incentives for individual income tax. The workforce housing tax incentives program replaced the eligible housing business enterprise zone program. An eligible business under the workforce housing tax incentives program must be approved by the economic development authority. The administrative rules for the workforce housing tax incentives program for the economic development authority may be found at 261—Chapter 48. The general assembly has mandated that the economic development authority and the department of revenue adopt rules to jointly administer Iowa Code sections 15.351 to 15.356. In general, the economic development authority is responsible for evaluating whether projects meet the requirements for a workforce housing tax incentives program while the department of revenue administers tax credit claims and transfers.

42.53(1) Definitions.

“Costs directly related” means the same as defined in rule 261—48.3(15).

“Qualifying new investment” means the same as defined in rule 261—48.3(15).

42.53(2) Workforce housing tax incentives. The economic development authority will allocate no more than \$20 million in tax incentives for this program for any fiscal year, \$5 million of which shall be reserved for allocation to qualified housing projects in small cities, as defined in Iowa Code section 15.352(10), that are registered on or after July 1, 2017. A housing business that has entered into an agreement with the economic development authority is eligible to receive the tax incentives described in the following paragraphs:

a. Sales tax refund. A housing business may claim a refund of the sales and use tax described in rule 701—12.19(15).

b. Investment tax credit.

(1) Computation of the credit. A housing business may claim a tax credit in an amount not to exceed 10 percent of the qualifying new investment in a housing project not located in a small city, or 20 percent of the qualifying new investment in a housing project located in a small city.

(2) Allocation of the tax credit to the individual owners of the entity or beneficiaries of an estate or trust. An individual may claim a tax credit if the housing business is a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the partnership, limited liability company, S corporation, estate, or trust.

(3) Refundability. Any tax credit in excess of the taxpayer's liability for the tax year is not refundable.

(4) Carryforward. Any tax credit in excess of the taxpayer's liability may be credited to the tax liability for the following five years or until depleted, whichever is earlier.

42.53(3) Claiming the tax credit—information required. The taxpayer must receive a tax credit certificate from the economic development authority to claim the eligible housing business tax credit. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the date the project was completed, the amount of the eligible housing business tax credit and the tax year for which the credit may be claimed. In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.53(5). The tax credit certificate must be included with the income tax return for the tax period in which the housing is ready for occupancy.

42.53(4) Basis adjustment. The increase in the basis of the property that would otherwise result from the qualifying new investment shall be reduced by the amount of the investment tax credit. For example, if a new housing project had qualifying new investment of \$1 million which resulted in a \$100,000 investment tax credit for Iowa tax purposes, the basis of the property for Iowa income tax purposes would be \$900,000.

42.53(5) Transfer of the credit.

a. Submission of transferred tax credit certificate to the department—information required. Tax credit certificates issued under an agreement entered into pursuant to subrule 42.53(3) may be transferred to any person. Within 90 days of transfer, the transferee shall submit the transferred tax credit certificate to the department of revenue along with a statement containing the transferee's name, tax identification number, and address, the denomination that each replacement tax credit certificate is to carry, and any other information required by the department of revenue. However, tax credit certificate amounts of less than the minimum amount established in rule by the economic development authority shall not be transferable.

b. Issuance of replacement certificate by the department. Within 30 days of receiving the transferred tax credit certificate and the transferee's statement, the department of revenue shall issue one or more replacement tax credit certificates to the transferee. Each replacement tax credit certificate must contain the information required for the original tax credit certificate and must have the same expiration date that appeared on the transferred tax credit certificate.

c. Claiming the transferred tax credit. A tax credit shall not be claimed by a transferee under this rule until a replacement tax credit certificate identifying the transferee as the proper holder has been issued. The transferee may use the amount of the tax credit transferred for any tax year the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income, or franchise tax purposes.

d. Unlimited number of transferees and subsequent transfers. There is no limitation on the number of transferees to whom the credit may be transferred. There is no limitation on the number of times that the credit may be retransferred by a transferee. The transferor may divide the credit into multiple credits of alternate denominations so long as the resulting credits are for amounts of no less than the minimum amount established in rule by the economic development authority.

e. Carryforward limitations on transferees. The transferee may use the amount of the transferred tax credit for any tax year that the original transferor could have claimed the tax credit. The carryforward limitations described in subparagraph 42.53(2)“b”(4) shall apply.

42.53(6) Repayment of benefits. If the housing business fails to maintain the requirements of Iowa Code section 15.353, the taxpayer may be required to repay all or a portion of the tax incentives the taxpayer received. Irrespective of the fact that the statute of limitations to assess the taxpayer for repayment of the income tax credit may have expired, the department may proceed to collect the tax incentives forfeited by failure of the taxpayer to maintain the requirements of Iowa Code section 15.353. This repayment is required because it is a recovery of an incentive, rather than an adjustment to the taxpayer’s tax liability. Details on the calculation of the repayment can be found in 261—subrule 187.5(4) of the administrative rules of the economic development authority. If the business is a partnership, limited liability company, S corporation, estate or trust where the income of the taxpayer is taxed to the individual owner(s) of the business, the department may proceed to collect the tax incentives against the partners, members, shareholders or beneficiaries to whom the tax incentives were passed through. See Decision of the Administrative Law Judge in *Damien & Colette Trebilcock, et al.*, Docket No. 11DORF 042-044, June 11, 2012.

This rule is intended to implement Iowa Code sections 15.354 and 15.355.
[ARC 1744C, IAB 11/26/14, effective 12/31/14; ARC 3837C, IAB 6/6/18, effective 7/11/18]

701—42.54(404A,422) Historic preservation and cultural and entertainment district tax credit for projects registered on or after July 1, 2014, and before August 15, 2016. For projects registered before August 15, 2016, the department of cultural affairs is authorized by the general assembly to award tax credits for a percentage of the qualified rehabilitation expenditures on a qualified rehabilitation project as described in the historic preservation and cultural and entertainment district tax credit program, Iowa Code chapter 404A. The program is administered by the department of cultural affairs with the assistance of the department of revenue. The general assembly has mandated that the department of cultural affairs and the department of revenue adopt rules to jointly administer Iowa Code chapter 404A. In general, the department of cultural affairs is responsible for evaluating whether projects comply with the prescribed standards for rehabilitation while the department of revenue is responsible for evaluating whether projects comply with the tax aspects of the program.

2014 Iowa Acts, House File 2453, amended the historic preservation and cultural and entertainment district tax credit program effective July 1, 2014. The department of revenue’s provisions for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014, are found in rule 701—42.19(404A,422). The department of revenue’s provisions for projects registered on or after July 1, 2014, and before August 15, 2016, are found in this rule. The department of cultural affairs’ rules related to this program may be found at 223—Chapter 48.

2016 Iowa Acts, House File 2443, amended the program and transferred primary responsibility for its administration to the economic development authority effective August 15, 2016. Effective August 15, 2016, the program is administered by the economic development authority with the assistance of the department of cultural affairs and the department of revenue. The department of revenue’s provisions for projects registered on or after August 15, 2016, are found in rule 701—42.55(404A,422). The economic development authority’s rules related to the program may be found at 261—Chapter 49. When adopted, the department of cultural affairs’ rules related to the program will be found in 223—Chapter 48.

Notwithstanding anything contained herein to the contrary, the department of cultural affairs shall not reserve tax credits under 2013 Iowa Code chapter 404A as amended by 2013 Iowa Acts, chapter 112, section 1, for applicants that do not have an approved Part 2 application and a tax credit reservation on or before June 30, 2014. Projects with approved Part 2 applications and provisional tax credit reservations on or before June 30, 2014, shall be governed by 2013 Iowa Code chapter 404A as amended by 2013 Iowa Acts, chapter 112, section 1; by 223—Chapter 48, Division I; and by rule 701—42.19(404A,422). Projects registered on or after July 1, 2014, but before August 15, 2016, shall be governed by 2014 Iowa Code chapter 404A as amended by 2014 Iowa Acts, House File 2453; by 223—Chapter 48, Division II; and by this rule. Projects registered on or after August 15, 2016, shall be governed by 2016 Iowa

Code chapter 404A as amended by 2016 Iowa Acts, House File 2443; by 261—Chapter 49; and by rule 701—42.55(404A,422).

42.54(1) *Application, registration, and agreement for the historic preservation and cultural and entertainment district tax credit.* Taxpayers that want to claim an income tax credit for completing a qualified rehabilitation project must submit an application for approval of the project. The application forms and instructions for the historic preservation and cultural and entertainment district tax credit are available on the department of cultural affairs' website. Once a project is registered, the taxpayer must enter into an agreement with the department of cultural affairs to be eligible for the credit.

42.54(2) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is a maximum of 25 percent of the qualified rehabilitation expenditures verified by the department of cultural affairs and the department of revenue following project completion, up to the amount specified in the agreement between the taxpayer and the department of cultural affairs.

42.54(3) *Qualified rehabilitation expenditures.* "Qualified rehabilitation expenditures" means the same as defined in rule 223—48.22(404A) of the historical division of the department of cultural affairs. In general, the department of cultural affairs evaluates whether expenditures comply with the prescribed standards for rehabilitation while the department of revenue evaluates whether expenditures comply with the tax requirements to be considered qualified rehabilitation expenditures, including whether the expenditures are in accordance with the requirements of Internal Revenue Code Section 47 and its related regulations.

a. Type of property and services eligible. In accordance with Iowa Code section 404A.1(6), the types of property and services claimed for the state tax credit must be "qualified rehabilitation expenditures" in accordance with Internal Revenue Code Section 47. Notwithstanding the foregoing sentence, expenditures incurred by an eligible taxpayer that is a nonprofit organization as defined in Iowa Code section 404A.1(4) shall be considered "qualified rehabilitation expenditures" if they are for "structural components," as that term is defined in Treasury Regulation § 1.48-1(e)(2), and for amounts incurred for architectural and engineering fees, site survey fees, legal expenses, insurance premiums, development fees and other construction-related costs.

b. Effect of financing sources on eligibility of expenditures. Qualified rehabilitation expenditures do not include expenditures financed by federal, state, or local government grants or forgivable loans unless otherwise allowed under Section 47 of the Internal Revenue Code. For an eligible taxpayer that is a nonprofit organization as defined in Iowa Code section 404A.1(4) that is not eligible for the federal rehabilitation credit, or another person that is not eligible for the federal rehabilitation credit, expenditures financed with federal, state, or local government grants or forgivable loans are not qualified rehabilitation expenditures.

42.54(4) *Completion of the qualified rehabilitation project and claiming the tax credit on the Iowa return.* After the taxpayer completes a qualified rehabilitation project, the taxpayer will be issued a certificate of completion of the project from the department of cultural affairs if the project complies with the federal standards, as defined in rule 223—48.22(404A). After the department of cultural affairs and the department of revenue verify the taxpayer's eligibility for the tax credit, the department of cultural affairs shall issue a tax credit certificate.

a. Claiming the credit. For the taxpayer to claim the credit, the certificate must be included with the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the income tax return for any tax year within the five years following the tax year of project completion. Taxpayers that elect to delay claiming the credit to a later tax year return as described in this paragraph are subject to the carryforward limitations described in paragraph 42.54(4)"d" below. The credit may be claimed on an amended return so long as the amended return is filed within the statute of limitations applicable to the tax year for which the amended tax return is being filed.

b. Information required. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed, the amount of the historic preservation and cultural and entertainment district tax credit, and, if applicable, an indication of whether the credit is nonrefundable (see paragraph

42.54(4)“c” below). In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.54(5). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, and the tax credit is allocated to the owners or beneficiaries of the entity, a list of the owners or beneficiaries and the amount of credit allocated to each owner or beneficiary shall be provided with the certificate.

c. Refundability. A historic preservation and cultural and entertainment district tax credit in excess of the taxpayer’s tax liability is fully refundable with interest computed under Iowa Code section 422.25. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year. To receive a refundable credit, the taxpayer must elect to receive the credit as refundable at the Part 3 stage of the application process administered by the department of cultural affairs. Once the taxpayer elects to receive a nonrefundable credit, the taxpayer cannot elect to change the credit to a refundable credit or vice versa. See department of cultural affairs’ 223—Chapter 48. If the taxpayer is a transferee, the taxpayer may elect to receive the credit as refundable or nonrefundable when the taxpayer applies to the department of revenue for transfer of the tax credit as described in subrule 42.54(5).

d. Carryforward. If the taxpayer elects to receive a nonrefundable historic preservation and cultural and entertainment district tax credit as described in paragraph 42.54(4)“b,” the amount in excess of the taxpayer’s tax liability may be carried forward for five years following the tax year in which the project is completed, or until it is depleted, whichever is earlier. A tax credit shall not be carried back to a tax year prior to the tax year in which the taxpayer is first eligible to claim the credit. Regardless of whether the taxpayer elects to claim the tax credit on a tax return for a year that is later than the year of project completion as described in paragraph 42.54(4)“a,” the taxpayer must utilize the entire credit within five years following the tax year of the project completion as described in this paragraph; any credit amount that is not utilized within the five-year carryforward period is forfeited. The five-year carryforward limitation does not apply if the taxpayer elects to receive a refundable credit, the excess of which may be credited to future tax years as an overpayment.

e. Allocation of historic preservation and cultural and entertainment district tax credits to the individual owners of the entity or beneficiaries of an estate or trust. A partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. The credit does not have to be allocated based on the pro rata share of earnings of the partnership, limited liability company or S corporation. For an individual claiming a tax credit of an estate or trust, the amount claimed by the individual shall be based upon the pro rata share of the individual’s earnings from the estate or trust.

42.54(5) Transfer of the historic preservation and cultural and entertainment district tax credit. The historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. The transferee may use the amount of the tax credit transferred against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, for any tax year the original transferor could have claimed the tax credit. Transferees must elect to receive either a refundable or nonrefundable tax credit. Once the transferee elects to receive a nonrefundable credit, the transferee cannot elect to change the credit to a refundable credit or vice versa. A tax credit certificate of less than \$1,000 shall not be transferable.

a. Transfer process—information required. Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue along with a statement that contains the transferee’s name, address and tax identification number, the amount of the tax credit being transferred, an election to receive either a refundable or nonrefundable tax credit, and the amount of all consideration provided in exchange for the tax credit and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the tax credit transferee

shall describe the nature of the nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The tax credit transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The certificate must have the same information required for the original tax credit certificate and must have the same expiration date as the original tax credit certificate. The transferee may not claim a tax credit until a replacement certificate identifying the transferee as the proper holder has been issued.

b. Consideration. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

c. Unlimited number of transferees and subsequent transfers. There is no limitation on the number of transferees to whom the credit may be transferred. There is no limitation on the number of times that the credit may be retransferred by a transferee. The transferor may divide the credit into multiple credits of alternate denominations so long as the resulting credits are for amounts of no less than \$1,000.

d. Carryforward limitations on transferees. The transferee may use the amount of the transferred tax credit for any tax year that the original transferor could have claimed the tax credit. The carryforward limitations described in paragraph 42.54(4) “d” shall apply.

42.54(6) Appeals. Challenges to an action by the department of revenue related to tax credit transfers, the claiming of tax credits, tax credit revocation, or repayment or recovery of tax credits must be brought pursuant to 701—Chapter 7.

This rule is intended to implement Iowa Code chapter 404A as amended by 2016 Iowa Acts, House File 2443, and Iowa Code section 422.11D.

[ARC 1968C, IAB 4/15/15, effective 5/20/15; ARC 2928C, IAB 2/1/17, effective 3/8/17]

701—42.55(404A,422) Historic preservation and cultural and entertainment district tax credit for projects registered on or after August 15, 2016. The economic development authority is authorized by the general assembly to award tax credits for a percentage of the qualified rehabilitation expenditures on a qualified rehabilitation project as described in the historic preservation and cultural and entertainment district tax credit program, Iowa Code chapter 404A. The program is administered by the economic development authority with the assistance of the department of cultural affairs and the department of revenue. The general assembly has mandated that the economic development authority, the department of cultural affairs and the department of revenue adopt rules as necessary to administer Iowa Code chapter 404A. In general, the department of revenue is responsible for administering tax credit transfers and processing and auditing tax credits claimed on returns. For the economic development authority’s rules on the credit program, see 261—Chapter 49. For the department of cultural affairs’ rules on the credit program, see 223—Chapter 48.

42.55(1) Program transition. 2016 Iowa Acts, House File 2443, made several changes to the credit program, including transferring primary responsibility for the program’s administration from the department of cultural affairs to the economic development authority. Projects registered prior to August 15, 2016, remain under the purview of the department of cultural affairs, with assistance from the department of revenue. For department of revenue rules related to projects registered prior to August 15, 2016, see rules 701—42.54(404A,422) and 701—42.19(404A,422).

42.55(2) Application, registration, and agreement for the historic preservation and cultural and entertainment district tax credit. For rules on the application, registration, and agreement process, see economic development authority rules, 261—Chapter 49.

42.55(3) *Computation of the amount of the historic preservation and cultural and entertainment district tax credit.* The amount of the historic preservation and cultural and entertainment district tax credit is a maximum of 25 percent of the qualified rehabilitation expenditures verified by the economic development authority following project completion, up to the amount specified in the agreement between the taxpayer and the economic development authority. For more information on the credit computation, see economic development authority rules, 261—Chapter 49. The amount remains subject to audit by the department of revenue when the credit is claimed on the taxpayer's tax return.

42.55(4) *Qualified rehabilitation expenditures.* "Qualified rehabilitation expenditures" means the same as defined in Iowa Code section 404A.1(7) and rule 261—49.5(404A) of economic development authority rules. In the event of an audit, the department of revenue evaluates whether expenditures comply with the agreement between the economic development authority and the eligible taxpayer, as well as with applicable statutes and rules, including Internal Revenue Code Section 47 and its related regulations.

42.55(5) *Completion of the qualified rehabilitation project and claiming the tax credit.* After the economic development authority verifies the taxpayer's eligibility for the tax credit, the economic development authority shall issue a tax credit certificate. For more information on credit certificate issuance, see economic development authority rules, 261—Chapter 49.

a. Claiming the credit. For the taxpayer to claim the credit, the certificate must be included with the taxpayer's income tax return for the tax year in which the rehabilitation project is completed or the income tax return for any year within the five years following the year of project completion. Taxpayers that elect to delay claiming the credit to a later year's return as described in this paragraph are subject to the carryforward limitations described in paragraph 42.55(5) "d" below. The credit may be claimed on an amended return so long as the amended return is filed within the statute of limitations applicable to the tax year for which the amended tax return is being filed.

b. Information required. The tax credit certificate shall include the taxpayer's name, the taxpayer's address, the taxpayer's tax identification number, the address or location of the rehabilitation project, the date the project was completed, the amount of the historic preservation and cultural and entertainment district tax credit, and, if applicable, an indication of whether the credit is nonrefundable (see paragraph 42.55(5) "c" below). In addition, the tax credit certificate shall include a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred, as provided in subrule 42.55(6). In addition, if the taxpayer is a partnership, limited liability company, estate or trust, and the tax credit is allocated to the owners or beneficiaries of the entity, a list of the owners or beneficiaries and the amount of credit allocated to each owner or beneficiary shall be provided with the certificate.

c. Refundability. A historic preservation and cultural and entertainment district tax credit in excess of the taxpayer's tax liability is fully refundable with interest computed under Iowa Code section 422.25. In lieu of claiming the refund, the taxpayer may elect to have the overpayment credited to the tax liability for the following tax year. To receive a refundable credit, the taxpayer must elect to receive the credit as refundable at the Part 3 stage of the application process administered by the economic development authority. See the economic development authority's rule 261—49.15(404A). Once the taxpayer elects to receive a nonrefundable credit, the taxpayer cannot elect to change the credit to a refundable credit or vice versa. If the taxpayer is a transferee, the taxpayer may elect to receive the credit as refundable when the taxpayer applies to the department of revenue for transfer of the tax credit as described in subrule 42.55(6).

d. Carryforward. If the taxpayer elects to receive a nonrefundable historic preservation and cultural and entertainment district tax credit as described in paragraph 42.55(5) "b," the amount in excess of the taxpayer's tax liability may be carried forward for five years following the tax year in which the project is completed, or until it is depleted, whichever is earlier. A tax credit shall not be carried back to a tax year prior to the tax year in which the taxpayer is first eligible to claim the credit. Regardless of whether the taxpayer elects to claim the tax credit on a tax return for a year that is later than the year of project completion as described in paragraph 42.55(5) "a," the taxpayer must utilize the entire credit within five years following the tax year of the project completion as described in this

paragraph; any credit amount that is not utilized within the five-year carryforward period is forfeited. The five-year carryforward limitation does not apply if the taxpayer elects to receive a refundable credit, the excess of which may be credited to future tax years as an overpayment.

e. Allocation of historic preservation and cultural and entertainment district tax credits to the individual owners of the entity or beneficiaries of an estate or trust. A partnership, limited liability company or S corporation may designate the amount of the tax credit to be allocated to each partner, member or shareholder. The credit does not have to be allocated based on the pro rata share of earnings of the partnership, limited liability company or S corporation. For an individual claiming a tax credit of an estate or trust, the amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the estate or trust.

42.55(6) *Transfer of the historic preservation and cultural and entertainment district tax credit.* The historic preservation and cultural and entertainment district tax credit certificates may be transferred to any person or entity. The transferee may use the amount of the tax credit transferred against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, for any tax year that the original transferor could have claimed the tax credit. Transferees must elect to receive either a refundable or nonrefundable tax credit. Once the transferee elects to receive a nonrefundable credit, the transferee cannot elect to change the credit to a refundable credit or vice versa. A tax credit certificate of less than \$1,000 shall not be transferable.

a. Transfer process—information required. Within 90 days of transfer of the tax credit certificate, the transferee must submit the transferred tax credit certificate to the department of revenue along with a statement that contains the transferee's name, address and tax identification number, the amount of the tax credit being transferred, an election to receive either a refundable or nonrefundable tax credit, and the amount of all consideration provided in exchange for the tax credit and the names of recipients of any consideration provided in exchange for the tax credit. If a payment of money was any part of the consideration provided in exchange for the tax credit, the transferee shall list the amount of the payment of money in its statement to the department of revenue. If any part of the consideration provided in exchange for the tax credit included nonmonetary consideration, including but not limited to any promise, representation, performance, discharge of debt or nonmonetary rights or property, the tax credit transferee shall describe the nature of the nonmonetary consideration and disclose any value the transferor and transferee assigned to the nonmonetary consideration. The tax credit transferee must indicate on its statement to the department of revenue if no consideration was provided in exchange for the tax credit. Within 30 days of receiving the transferred tax credit certificate and the statement from the transferee, the department of revenue will issue the replacement tax credit certificate to the transferee. If the transferee is a partnership, limited liability company or S corporation, the transferee shall provide a list of the partners, members or shareholders and information on how the historic preservation and cultural and entertainment district tax credit should be divided among the partners, members or shareholders. The transferee shall also provide the tax identification numbers and addresses of the partners, members or shareholders. The certificate must have the same information required for the original tax credit certificate and must have the same expiration date as the original tax credit certificate. The transferee may not claim a tax credit until a replacement certificate identifying the transferee as the proper holder has been issued.

b. Consideration. Any consideration received for the transfer of the tax credit shall not be included in Iowa taxable income for individual income, corporation income or franchise tax purposes. Any consideration paid for the transfer of the tax credit shall not be deducted from Iowa taxable income for individual income, corporation income or franchise tax purposes.

c. Unlimited number of transferees and subsequent transfers. There is no limitation on the number of transferees to whom the credit may be transferred. There is no limitation on the number of times that the credit may be retransferred by a transferee. The transferor may divide the credit into multiple credits of alternate denominations so long as the resulting credits are for amounts of no less than \$1,000.

d. Carryforward limitations on transferees. The transferee may use the amount of the transferred tax credit for any tax year that the original transferor could have claimed the tax credit. The carryforward limitations described in paragraph 42.55(4) "d" shall apply.

42.55(7) Appeals. Challenges to an action by the department of revenue related to tax credit transfers, the claiming of tax credits, tax credit revocation, or repayment or recovery of tax credits must be brought pursuant to 701—Chapter 7.

This rule is intended to implement Iowa Code chapter 404A as amended by 2016 Iowa Acts, House File 2443, and Iowa Code section 422.11D.
[ARC 2928C, IAB 2/1/17, effective 3/8/17]

701—42.56(15,422) Renewable chemical production tax credit program. An eligible business that has received a renewable chemical production tax credit certificate from the economic development authority may claim a tax credit against individual income tax. The credit is equal to the product of five cents multiplied by the number of pounds of renewable chemicals produced in Iowa from biomass feedstock by the eligible business during a given production year, subject to the limitations described in Iowa Code sections 15.315 through 15.322, 261—Chapter 81, and this rule. The economic development authority's rules on eligibility for the credit may be found in 261—Chapter 81.

42.56(1) Application and agreement for the credit. To be eligible for the tax credit, the eligible business must apply to and enter into an agreement with the economic development authority. The economic development authority's rules on the application and agreement process may be found in 261—Chapter 81.

42.56(2) Computation of the amount of credit and certificate issuance. Upon establishing that all requirements of the program and the agreement have been fulfilled and verifying the taxpayer's eligibility for the tax credit, the economic development authority calculates the credit. Then the economic development authority issues the related tax credit certificate to the eligible business stating the amount of the renewable chemical production tax credit that the eligible business may claim. A tax credit certificate shall not be issued by the economic development authority prior to July 1, 2018. The economic development authority's rules on credit certificate issuance may be found in 261—Chapter 81.

42.56(3) Claiming the tax credit.

a. Claiming the credit, generally. To claim the credit, a taxpayer must include one or more tax credit certificates with the taxpayer's tax return for the tax year during which the eligible business was issued the tax credit certificate or certificates. If the taxpayer claiming the credit has already filed a return for the tax year for which the credit certificate was issued, the taxpayer may claim the credit on an amended return. The taxpayer must file the amended return within the statute of limitations applicable to such amended return. No tax credit may be claimed under this program by a taxpayer prior to September 1, 2018.

b. Claiming the credit of a pass-through entity. To claim the credit of an eligible business that is a pass-through entity, an individual taxpayer must claim the credit on the tax return for the tax year during which the eligible business received the tax credit certificate. Such tax year may be either the tax year of the eligible business or of the individual.

EXAMPLE: A partnership has a fiscal year of September 2017 through August 2018. The partnership receives a renewable chemical production tax credit certificate under this program in July 2018, which is during the partnership's 2017 tax year. A partner in the partnership files individual returns on a calendar year basis, which means that the credit was issued in the partner's 2018 tax year. That partner may file an amended 2017 tax return to claim the credit based on the partnership's tax year, or that partner may claim the credit on the partner's 2018 tax return based on the partner's own tax year.

c. Information required. The tax credit certificate shall include the taxpayer's name, address, tax identification number, the amount of the credit, the name of the eligible business, and any other information required by the department of revenue.

d. Allocation to the individual owners of the entity or beneficiaries of an estate or trust. An individual may claim the credit of a partnership, limited liability company, S corporation, cooperative organized under Iowa Code chapter 501 and filing as a partnership for tax purposes, estate, or trust electing to have income taxed directly to the individual. The amount claimed by the individual shall be based on the pro rata share of the individual's earnings from the partnership, limited liability company, S corporation, cooperative, estate, or trust.

e. Refundability. Any credit in excess of the tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment shown on the taxpayer's final, completed return credited to the tax liability for the following tax year.

f. Transferability. Tax credit certificates shall not be transferred to any other person.

g. Rescission and recapture. The tax credit certificate, unless rescinded by the economic development authority, shall be accepted by the department of revenue, subject to any conditions or restrictions placed upon the face of the tax credit certificate by the economic development authority and subject to the limitations of the program. Should the economic development authority reduce, terminate, or rescind any tax credits issued under the program, the eligible business may be subject to the repayment or recapture of any credits already claimed. The economic development authority's rules related to the program may be found in 261—Chapter 81. The repayment of tax credits or recapture by the department of revenue shall be accomplished in the same manner as provided in Iowa Code section 15.330(2).

This rule is intended to implement Iowa Code section 422.10B.

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TRANSPORTATION DEPARTMENT[761]

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VEHICLES

CHAPTER 400

VEHICLE REGISTRATION AND CERTIFICATE OF TITLE

[Prior to 6/3/87, Transportation Department[820]—(07.D)Ch 11]

761—400.1(321) Definitions. The definitions in Iowa Code section 321.1 are hereby made part of this chapter. In addition, the following words and phrases, when used in Iowa Code chapter 321 or this chapter, shall have the meanings respectively ascribed to them, except when the context otherwise requires.

“Certificate of title” means a document issued by the appropriate official which contains a statement of the owner’s title, the name and address of the owner, a description of the vehicle, a statement of all security interests and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms “title certificate,” “title only,” and “title” shall be synonymous with the term “Certificate of title.”

“Dealer’s or manufacturer’s stock or inventory” means a vehicle owned by a dealer which is being held for sale or trade and for which the dealer has a duly assigned ownership document as required by Iowa Code section 321.45.

“Driverless-capable vehicle” means the same as defined in rule 761—380.2(321).

“Electric vehicle annual registration fee” means an annual registration fee for a battery electric or plug-in hybrid electric motor vehicle as provided in Iowa Code sections 321.116 and 321.117. Unless otherwise provided, for purposes of this chapter, any reference to a registration fee shall also include an annual registration fee for a battery electric or plug-in hybrid electric motor vehicle if that vehicle is a battery electric or plug-in hybrid electric motor vehicle as defined in Iowa Code sections 321.116 and 321.117.

“Electronic” means as defined in Iowa Code section 554D.103.

“Electronic record” means as defined in Iowa Code section 554D.103.

“Electronic signature” means as defined in Iowa Code section 554D.103.

“End user” means a person or entity that directly uses the services of an electronic registration and titling (ERT) service provider to submit an electronic application for certificate of title or registration of a vehicle.

“ERT service provider” means a person or entity authorized by the department under subrule 400.3(17) to submit electronic applications for certificate of title or registration of a vehicle on behalf of an end user to a county treasurer.

“Farm trailer” means a trailer used exclusively by a farmer in the conduct of the farmer’s agricultural operation. The term shall not include a “semitrailer.”

“Final-stage manufacturer” means as defined in Iowa Code section 322.2.

“Half-year fee” means the first semiannual installment of an annual registration fee but does not include an electric vehicle annual registration fee. The term “half-year registration” shall be synonymous with the term “half-year fee.”

“Hearse” means a motor vehicle used exclusively to transport a deceased person.

“Lien” means an interest in a vehicle which secures payment or performance of an obligation. The term “security interest” shall be synonymous with the term “lien.”

“Manufacturer’s certificate of origin” means a certification signed by the manufacturer, distributor or importer that the vehicle described has been transferred to the person or dealer named and that the transfer is the first transfer of the vehicle in ordinary trade and commerce.

1. The terms “manufacturer’s statement,” “importer’s statement or certificate,” “MSO” and “MCO” shall be synonymous with the term “manufacturer’s certificate of origin.”

2. In addition to the requirements of Iowa Code subsection 321.45(1), the certificate shall contain a description of the vehicle which includes the make, model, style and vehicle identification number. The description of a motorized bicycle shall also specify the maximum speed.

3. For 1992 and subsequent model year vehicles, the form used for manufacturers' certificates of origin shall be the universal form adopted in 1990 by the American Association of Motor Vehicle Administrators (AAMVA). This requirement does not apply to trailer-type vehicles. A copy of this universal form may be obtained from the vehicle and motor carrier services bureau at the address in subrule 400.6(1).

"Model year," except where otherwise specified, means the year of original manufacture or the year certified by the manufacturer. For purposes of titling and registration, the model year shall advance one year each January 1.

"Registered" means that the appropriate registration fee has been paid for a vehicle and a registration card evidencing payment has been issued to the owner.

"Registration card" means a document issued to the owner of a vehicle by the appropriate agency whose duty it is to register vehicles, which contains the name and address of the owner and a description of the vehicle, and which is issued to the owner when the vehicle has been registered. The terms "registration certificate," "registration receipt" and "registration renewal receipt" are synonymous with the term "registration card."

"Security interest" means an interest in a vehicle which secures payment or performance of an obligation. The term "lien" shall be synonymous with the term "security interest."

"Social security number" means a social security number issued by the United States government.

This rule is intended to implement Iowa Code sections 321.1, 321.8, 321.20, 321.23, 321.24, 321.40, 321.45, 321.50, 321.116, 321.117, 321.123, 321.134, 321.157 and 322.2.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 5178C, IAB 9/9/20, effective 10/14/20; ARC 5893C, IAB 9/8/21, effective 10/13/21]

761—400.2(321) Vehicle registration and certificate of title—general provisions.

400.2(1) *Vehicles subject to registration.* A vehicle subject to registration under the laws of Iowa shall be required to be registered at the time the vehicle is first operated or moved upon a highway in this state.

400.2(2) *Vehicles exempt from titling or registration.* A certificate of title shall not be issued for a vehicle which is exempt from the titling or registration provisions of Iowa Code chapter 321, unless issuance of a certificate of title is specifically authorized in chapter 321.

400.2(3) *Issuance of a certificate of title upon payment of registration fees.* Except as otherwise provided in Iowa Code chapter 321 or this chapter of rules, the current year registration fee and any delinquent registration fees and penalties, if any, shall be paid prior to issuance of a certificate of title.

400.2(4) *Trailers with an empty weight of 2000 pounds or less.* Certificates of title shall not be issued for trailers with an empty weight of 2000 pounds or less. However, these trailers shall be subject to the registration fees provided in Iowa Code section 321.123.

400.2(5) *Vehicles owned by the government.* A certificate of title shall be issued for a vehicle owned by the government when the vehicle is first registered. However, vehicles owned by the government shall be exempted from registration and titling fees. Also, a certificate of title shall not be issued for a government-owned vehicle if a certificate of title would not be issued if the vehicle were owned by someone other than the government.

400.2(6) *Vehicles leased by the government.* Vehicles leased by the government for a period of 60 days or more are exempted from payment of registration fees. A copy of the lease agreement, certificate of lease, or other evidence that the vehicle is being leased by the government shall be required in order to obtain this exemption. However, the lessor is not exempted from the requirements for obtaining a certificate of title as set out in Iowa Code chapter 321 and these rules, including payment of the appropriate certificate of title fee.

400.2(7) *Special mobile equipment.* Rescinded IAB 3/7/90, effective 4/11/90.

400.2(8) *Private school buses, fire trucks, authorized emergency vehicles, and transit buses.* In accordance with Iowa Code sections 321.18, 321.19 and 321.22, private school buses, fire trucks not owned or operated for a pecuniary profit, certain authorized emergency vehicles owned and operated by nonprofit organizations, and urban and regional transit system buses are exempt from the payment

of registration fees. However, these vehicles are not exempt from the requirements for obtaining a certificate of title as set out in Iowa Code chapter 321, including payment of the appropriate certificate of title fee.

400.2(9) Towable recreational vehicles. For purposes of registration and titling under Iowa Code chapter 321 and this chapter, a towable recreational vehicle as defined in Iowa Code section 322C.2 shall be considered a travel trailer or fifth-wheel travel trailer, as those terms are defined in Iowa Code section 321.1, as applicable.

This rule is intended to implement Iowa Code sections 321.18 to 321.22, 321.24, 321.123 and 322C.2(19).

[ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.3(321) Application for certificate of title or registration for a vehicle.

400.3(1) Application form. To apply for a certificate of title or registration for a vehicle, the owner of the vehicle shall complete an application form prescribed by the department, which may be electronic. Application shall be made in accordance with Iowa Code chapter 321, these rules, and other applicable provisions of law.

400.3(2) Full legal name. Full legal names shall be given on the application. Civilian or military titles and nicknames shall not be used.

400.3(3) Information about owner, lessee and primary user.

a. Iowa Code sections 321.20 and 321.109 list the information that must be disclosed by the owner, lessee and primary user on the application.

b. A firm, association, corporation, or trust that is not required to have a federal employer identification number shall disclose the social security number, Iowa driver's license number or Iowa nonoperator's identification card number of an authorized representative of the firm, association, corporation, or trust. The authorized representative of a trust is the trustee unless otherwise specified in the trust agreement or the certification of trust as defined in Iowa Code section 633A.4604.

400.3(4) Plate number and validation number. If the owner has registration plates that have been assigned to the owner and affixed to the vehicle, the owner shall list the plate number on the application form. The validation number from the validation sticker shall also be listed.

400.3(5) Birth or registration month. If the vehicle is owned by one individual, the individual's month of birth shall be listed on the application form and shall determine the registration year. If the vehicle is owned by two or three individuals, the month of birth of one of the individuals shall be listed and shall determine the registration year. If the vehicle is owned by a partnership, corporation, association, or governmental subdivision, the birth or registration month shall be left blank on the application; the county treasurer shall determine the month of registration.

400.3(6) Model year. The application shall include the model year of the vehicle.

400.3(7) Purchase information. The application shall include the date of purchase or acquisition and, if the vehicle was not purchased from a dealer, the purchase price.

400.3(8) Vehicle color. The application shall include the vehicle color.

400.3(9) Foreign registered vehicle. If the vehicle is registered in a foreign jurisdiction, the application shall include the date the vehicle was brought into Iowa.

400.3(10) Signature of applicant. The owner shall sign the application form in ink, unless submitted electronically.

400.3(11) Dealer certification.

a. If the vehicle is a new vehicle which has been sold to the owner by a dealer, as defined in Iowa Code section 321.1, the dealer shall certify the following on the application form: sale price of the vehicle, the amounts allowed for property traded in, nontaxable charges and rebates, the tax price of the vehicle, the date that a "Registration Applied For" card was issued, and the registration fee collected.

b. The certification shall include the dealer's number and name and shall be signed by the dealer or an authorized representative of the dealer. The signature may be electronic when the application form is submitted electronically in a manner approved by the department.

400.3(12) *Weigh ticket.* If application is being made to lower the tonnage on any motor truck, bus or truck tractor, the county treasurer may require a copy of a stamped weigh ticket issued by any public scale.

400.3(13) *Credits.* See rule 761—400.60(321) for:

Credit for unexpired registration fee.

Credit for transfer to spouse, parent or child.

Credit from/to apportioned registration.

Assignment of credit and registration plates from lessor to lessee.

400.3(14) *Leased vehicle.* As required by Iowa Code section 423.26, the lessor shall list the lease price of the vehicle on the application form.

400.3(15) *Affidavit of correction.* As provided in Iowa Code section 321.23A, the county treasurer or the department may accept an affidavit of correction on a form prescribed by the department.

a. The affidavit may be used only to correct those errors, erasures or alterations listed on the affidavit.

b. The affidavit must contain the signatures of all parties to the original error, erasure or alteration.

c. Only an original, notarized affidavit shall be accepted.

d. The affidavit must be surrendered with the document that contains the error, erasure or alteration to be corrected.

e. The affidavit may be accepted to correct errors, erasures or alterations on either an Iowa title or a foreign title.

400.3(16) *Driverless-capable vehicle.* As provided in Iowa Code sections 321.20 and 321.515 and rule 761—400.21(321), the applicant shall indicate on the application whether the vehicle is a driverless-capable vehicle as defined in rule 761—380.2(321).

400.3(17) *Electronic applications.*

a. Applications for certificate of title or registration of a vehicle may be submitted electronically via web-based services offered and maintained by ERT service providers authorized by the department. To be authorized to serve as an ERT service provider, the ERT service provider must establish to the satisfaction of the department that the ERT service provider has the technical, financial, legal, and administrative capacity to meet the department's requirements for submission of electronic applications and must execute an agreement, in a form and content determined by the department, that authorizes and permits the ERT service provider to interact with the department's vehicle title and registration system via an application program interface established by the department and to submit electronic applications on behalf of end users that choose to use the ERT service provider's services to submit an application electronically. Agreements executed by ERT service providers under this paragraph shall include provisions that address security, financial responsibility, privacy, termination, and any other matters deemed appropriate by the department.

b. An agreement executed by an ERT service provider is a condition of authorization and permission only. An ERT service provider authorized by the department is not a contractor, vendor, employee, or agent for the department, the state of Iowa, or any county treasurer accepting electronic applications, and shall not be entitled to compensation from the department, the state of Iowa, or any county treasurer for any service, transaction, or other act rendered as an ERT service provider. The ERT service provider remains solely liable and responsible for the ERT service provider's services and activities as an ERT service provider and shall defend, indemnify and hold harmless the department, any county treasurer, the state of Iowa, and its, or their agents, officers, heirs, assigns, and employees of and from any and all damages, claims, penalties, debts owed, or any other form of liability arising from or related to the ERT service provider's service, performance, errors, acts, or omissions. An ERT service provider that chooses to provide service under the department's permission and authorization does so at the ERT service provider's sole risk and has no claim or right against the department, any county treasurer, or the state of Iowa for fees, costs, profits, loss of profits, interruption of business, or

any other form of compensation, remuneration, liability, or damages arising from or related to the ERT service provider's activity as an ERT service provider or inability to serve as an ERT service provider.

c. An ERT service provider authorized by the department may establish web-based services to allow end users to submit applications via an electronic interface established and maintained by the ERT service provider and to submit the applications on behalf of the end user to county treasurers via the department's vehicle title and registration system and application program interface established by the department. In doing so, the ERT service provider is acting as a contractor or vendor for the end user and not the department, any county treasurer, or the state of Iowa, and remains solely responsible to the end user for any failure to perform or breach of performance or agreement. When the end user is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C, "end user" includes the motor vehicle dealer and any person with an interest in the vehicle that is the subject of the application. The ERT service provider may charge the end user a fee for services rendered as an ERT service provider.

d. In addition to the documentary fee authorized under Iowa Code section 322.19A, an end user that is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C may pass and charge to a customer the fees or costs incurred by the motor vehicle dealer to submit the customer's application through an ERT service provider's services as a third-party cost or fee, provided that the motor vehicle dealer discloses the charge to the customer before submitting the application. The documentary fee charged by the motor vehicle dealer shall not exceed the amount authorized by Iowa Code section 322.19A. Neither the ERT service provider nor the motor vehicle dealer shall charge a customer for creation or delivery of a "registration applied for" card.

e. An ERT service provider authorized by the department has no authority to approve or deny applications. Acceptance of an application by an ERT service provider is not approval of the application. An application is not considered to be formally submitted until it is electronically transmitted by the ERT service provider to the county treasurer via the department's vehicle title and registration system and the application program interface established by the department. The county treasurer remains responsible for approving or denying the application and may reject the application for any reason permitted or required by state or federal law or regulation.

f. An authorized ERT service provider is responsible for the ERT service provider's payment solution and for all payment transaction security and compliance with all applicable standards associated with the payment solution or solutions offered by the ERT service provider. The ERT service provider shall transfer title and registration fees collected by the ERT service provider directly to an account designated by the county treasurer responsible for the transaction via automated clearing house (ACH) transfer and the fees shall be available to the county treasurer no later than three business days following the submission of a transaction for which the fees were paid. Funds received by the ERT service provider shall be held until transfer to the county treasurer's account in a bank insured by the Federal Deposit Insurance Corporation. The ERT service provider shall be responsible for reconciling insufficient funds from an end user.

g. Fees submitted electronically are not deemed to be received until deposited into the county treasurer's account via completion of the ACH transfer. The end user remains responsible for fees submitted via an ERT service provider and the end user's responsibility for payment of any required fees is not waived or excused by the ERT service provider's failure to complete the transfer. As a condition of authorization and permission to serve as an ERT service provider and before the ERT service provider may offer services, the ERT service provider shall furnish a surety bond executed by the ERT service provider as principal and executed by a corporate surety company, licensed and qualified to do business within the state of Iowa. The bond shall run to the state of Iowa, be in the amount of \$150,000 and be conditioned upon the faithful compliance by the ERT service provider of all obligations imposed upon the ERT service provider by any applicable state or federal law or regulation, including the terms of this chapter, the authorizing agreement executed by the ERT service provider under this chapter, and any terms or conditions existing between the ERT service provider and any end user using the ERT service provider's services. The ERT service provider shall indemnify any end user that uses the ERT service provider's services of and from any loss or damage occasioned by the failure of the ERT service provider to so comply, including but not limited to the complete and timely submission to the county treasurer of

the title and registration fees required for a given transaction. The bond shall be filed with the department before the ERT service provider may begin or offer services as an ERT service provider. The aggregate liability of the surety shall not exceed the amount of the bond.

h. The ERT service provider shall provide accounting reports of all fees received and transferred to each respective county treasurer, in a manner determined by the department.

i. The ERT service provider shall submit to audits by the department and the state auditor, which shall be at least yearly but may be more frequently if determined necessary by the department or the state auditor.

j. An application submitted electronically must meet all legal requirements for the transaction in question, and no requirement shall be excused or waived as a result of submitting the transaction electronically. However, wherever a signature is required, the signature may be an electronic signature, as determined by the department and according to methods approved by the department. Wherever an electronic solution approved by the department requires the submission of scanned documents, the scanned documents shall be of a quality and resolution determined by the department, which shall at a minimum meet any applicable state or federal standard or requirement, and shall completely capture and represent the original document. The department and any county treasurer processing an application retain the right under Iowa Code section 321.13 to determine the genuineness, regularity, and legality of the application and any scanned document submitted as part of the application and may withhold approval of the application and require presentation of the original document whenever the scanned document is of insufficient quality, content, or appearance to determine the same. An end user that submits a scan of an original document as part of an electronic application shall retain the original document for a period of six months. An end user shall make all such original documents available for inspection by the department at the department's request. An end user that is a business entity shall retain the documents at the end user's principal place of business in Iowa. Anything in this paragraph notwithstanding, lessors required to retain a damage disclosure statement under Iowa Code section 321.69(4), and authorized vehicle recyclers licensed under Iowa Code chapter 321H and motor vehicle dealers licensed under Iowa Code chapter 322 required to retain damage disclosure statements under Iowa Code section 321.69(6) shall retain the original document for a period of five years from the date of the statement, as required therein.

k. An end user that is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C and that electronically submits an application on behalf of the person to whom the dealer is transferring the vehicle shall disclose to the person that the application will be submitted electronically and shall obtain the person's written authorization to submit the application on the person's behalf. The written authorization shall be retained at the motor vehicle dealer's principal place of business for a period of six months from the date of application and shall be available for inspection by the department at the department's request. The motor vehicle dealer shall also review with and disclose to the person all details of the application, before submitting the application, and shall provide a complete, true, and accurate copy of the application to the person immediately after submitting the application. The written authorization shall be submitted electronically as a scanned document with the electronic application.

l. An authorized ERT service provider shall retain all data, information, records, and electronic records associated with an electronic application or transaction submitted or transacted through the ERT service provider for a period of at least six months, or longer as required by applicable state or federal law or regulation, and shall make all such data, information, and records available to the department at the department's request. This includes but is not limited to the identity of the end user that initiated the electronic application or transaction. Identity information for end users shall be maintained at the entity and individual level, meaning that the ERT service provider must implement and maintain secure profile management that is capable of authenticating and verifying the identity of any entity that initiated the application or transaction and the individual officer, employee, or agent within the entity that was authorized by the entity to initiate the application or transaction.

m. The ERT service provider shall hold and protect all personal information as required by Iowa Code section 321.11 and the federal Driver's Privacy Protection Act, 18 U.S.C. §2721 et seq. (the DPPA), shall only use or release such personal information for purposes necessary to perform services as an ERT service provider, and shall release such personal information for no other purposes or use except as

required to comply with legal or administrative matters as permitted under the DPPA. The ERT service provider shall immediately advise the department of any suspected or actual unauthorized release of personal information or highly restricted personal information and shall notify the entity and individual whose personal information or highly restricted personal information was released in an unauthorized manner.

This rule is intended to implement Iowa Code sections 321.1, 321.8, 321.20, 321.23 to 321.26, 321.31, 321.34, 321.46, 321.105A, 321.109, 321.122, 321.515, 321.519, 322.19A and 423.26. [ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5893C, IAB 9/8/21, effective 10/13/21; ARC 6219C, IAB 3/9/22, effective 4/13/22]

761—400.4(321) Supporting documents required. This rule describes the basic supporting documents to be submitted by an applicant for a certificate of title or registration.

400.4(1) *New vehicle.* If application is made for a new vehicle, a manufacturer's certificate of origin, properly assigned to the applicant, shall be submitted. A manufacturer's certificate of origin shall not be accepted if the assignment to the applicant is made by any person other than the manufacturer, importer or distributor, a licensed motor vehicle dealer franchised to sell that line-make of vehicle, or a final-stage manufacturer motor vehicle dealer licensed under rule 761—425.11(322).

a. The first person, including a dealer not franchised to sell that line-make of vehicle, who is assigned the manufacturer's certificate of origin shall obtain a certificate of title and register the vehicle.

b. An uncanceled security interest noted on the reverse side of a manufacturer's certificate of origin (MCO) shall be noted as a separate security interest on the certificate of title, in addition to any security interest acknowledged by the applicant, unless the applicant indicates in the security interest area on the title application that the security interest is the same as the one noted on the reverse side of the MCO.

c. If a 1980 or subsequent model year vehicle is manufactured by a person other than the original manufacturer, both the original manufacturer's certificate of origin and the final-stage manufacturer's certificate of origin shall be submitted if the vehicle's original line-make is changed by the final-stage manufacturer. All assignments or reassignments of ownership of the vehicle shall be made on the final-stage manufacturer's certificate of origin. The face of the original manufacturer's certificate of origin shall be stamped in bold type with the statement: "Final-stage manufacturer's MCO has been issued on this vehicle." The original manufacturer's vehicle identification number shall be listed on the final-stage manufacturer's certificate of origin.

d. If a final-stage manufacturer is a motor vehicle dealer licensed under rule 761—425.11(322), the final-stage manufacturer may reassign the original manufacturer's certificate of origin to the retail buyer.

400.4(2) *Used vehicle registered or titled in this state.* The last issued certificate of title, properly assigned to the applicant, shall be submitted, unless the applicant is an insurer applying for a salvage certificate of title under Iowa Code section 321.52(4). An uncanceled security interest noted on the face of the certificate of title shall be noted on the face of the certificate of title issued to the applicant, in addition to any security interest acknowledged by the applicant. If the vehicle is not subject to titling provisions, the last issued registration receipt or bill of sale, properly assigned to the applicant, shall be submitted.

400.4(3) *Used vehicle from a foreign jurisdiction.* If the vehicle was subject to the issuance of a certificate of title in the foreign jurisdiction, the certificate of title issued by the foreign jurisdiction to the applicant or properly assigned to the applicant shall be submitted, unless the applicant is an insurer applying for a salvage certificate of title under Iowa Code section 321.52(4).

a. A security interest, noted on the face of the foreign certificate of title, which has not been canceled, shall be noted on the face of the certificate of title issued to the applicant, in addition to any security interest acknowledged by the applicant.

b. A certificate of title issued in a foreign jurisdiction may be assigned to a motor vehicle dealer in another jurisdiction, and the dealer may reassign the certificate of title to the applicant. An assignment or reassignment form issued by a foreign jurisdiction may be used with a foreign title to complete an

assignment or reassignment of ownership from a foreign motor vehicle dealer to the applicant, provided the ownership chain is complete.

c. An Iowa licensed motor vehicle dealer who acquires a vehicle registered in another state or country may reassign the foreign certificate of title to the applicant, as provided in Iowa Code subsection 321.48(2) and rule 761—400.27(321,322).

d. A person who registers a foreign vehicle under Iowa Code subsection 321.23(3) shall be issued a nontransferable-nonnegotiable registration. To transfer ownership of the vehicle, the owner must first obtain an Iowa certificate of title except as follows: If ownership is transferred to an Iowa licensed motor vehicle dealer as provided in Iowa Code subsection 321.23(3), the foreign certificate of title may be assigned to the dealer; the owner is not required to obtain an Iowa title. The dealer may then reassign the foreign title, as provided in Iowa Code subsection 321.48(2) and rule 761—400.27(321,322).

e. If the vehicle was not subject to the issuance of a certificate of title in the foreign jurisdiction, the registration document issued by the foreign jurisdiction to the applicant or properly assigned to the applicant shall be submitted.

(1) If the foreign registration document is not issued in the applicant's name and does not contain an assignment of ownership form, a bill of sale conveying ownership from the owner as listed on the foreign registration document to the applicant shall be submitted with the foreign registration document.

(2) Upon receipt of the foreign registration document, the county treasurer shall issue a nontransferable—nonnegotiable registration unless the foreign registration document has been approved by the department.

(3) Acceptance of the foreign registration document shall be determined by the department on an individual basis, if the county treasurer of the county where the certificate of title is to be issued cannot determine whether the document is acceptable.

f. If a trailer weighing 2000 lbs. or less is exempt from the issuance of a certificate of title and registration in the foreign jurisdiction, a bill of sale conveying ownership to the applicant, if acquired by a resident from a nonresident, or an affidavit of ownership signed by the applicant, if the applicant is establishing residence in this state, shall be submitted.

g. If a motor vehicle is exempt from the issuance of a certificate of title and registration in the foreign jurisdiction, the bonding procedures as provided in Iowa Code section 321.24 shall be followed.

400.4(4) *Used vehicle acquired by a resident of this state from a government agency.* If the vehicle was acquired from an agency of the federal government, the applicant shall surrender the government bill of sale, General Services Administration Form 97, or Internal Revenue Service Form 2435, properly assigned to the applicant. If the vehicle was acquired from the state of Iowa or a subdivision of government, the applicant shall surrender the Iowa certificate of title issued in the name of the agency, properly assigned to the applicant.

400.4(5) *Manufactured or mobile home.* If the vehicle described on the application is a manufactured or mobile home with an Iowa title, the applicant shall submit a tax clearance form to show that no taxes are owing, unless the title has been issued to a manufactured or mobile home retailer licensed under Iowa Code chapter 103A. The form may be obtained by any owner of record of the manufactured or mobile home from the county treasurer.

400.4(6) *Vehicle acquired by a resident of this state by operation of law.* If the vehicle was acquired by the applicant by operation of law as specified in Iowa Code section 321.47, the last issued certificate of title shall be submitted by the applicant, or when that is not possible, presentation of satisfactory proof of the applicant's ownership and right of possession to the vehicle shall be submitted by the applicant. Proof of ownership may consist of a foreclosure sale affidavit, artisan's or storage lien affidavit, affidavit of death intestate, abandoned vehicle sales receipt, peace officers bill of sale or court order. See also subrules 400.14(4) and 400.14(5).

400.4(7) *Foreign ownership document issued in a language other than English.* A foreign ownership document issued in a language other than English may be required to be reproduced in writing in English and certified to be a correct translation by a person qualified to translate that particular language. The English translation and certification shall be submitted with the foreign ownership document.

400.4(8) *Titles from foreign jurisdictions.*

a. Except as provided in paragraph “*b*” of this subrule, a certificate of title issued by a foreign jurisdiction shall not be accepted if the title contains an alteration or erasure.

b. An affidavit of correction form issued by a foreign jurisdiction that corrects the certificate of title issued by the foreign jurisdiction shall be accepted only for the reason listed on the affidavit of correction form. However, acceptance of an affidavit of correction form that corrects an odometer statement or a designation shall be determined by the department on an individual basis.

400.4(9) Applications in the name of trusts. An application in the name of a trust shall be accompanied by a copy of all documents creating or otherwise affecting the trust or by the certification of trust as defined in Iowa Code section 633A.4604.

a. The certification of trust may be signed by any trustee or the attorney for any trustee.

b. The application shall be signed by the number of trustees as specified in the trust agreement, and the applicant shall provide the department with the document or the certification of trust specifying the required signatories for the trust.

c. If a certification of trust is provided, one of the following shall apply:

(1) Any currently acting trustee may sign the application if the certification of trust states that such trustee may act individually.

(2) A majority of the trustees must sign the application if the certification of trust states that the trustees must act by majority decision.

(3) All currently acting trustees must sign the application if the certification of trust states that the trustees must act by unanimous decision.

d. A certification of trust must meet the requirements of Iowa Code section 633A.4604, including but not limited to providing the names of all the currently acting trustees. If there are two or more currently acting trustees, the certification of trust must state whether the trustees may act individually, whether the trustees must act by majority decision or whether the trustees must act by unanimous decision. If the certification of trust does not meet said requirements, the certification of trust will be considered invalid for the purposes of the application.

e. Each signature on the application shall be followed by the words “as trustee.”

400.4(10) Driverless-capable vehicles. If an application is made for a driverless-capable vehicle, the department may require the application to be accompanied by the operational design domain.

400.4(11) Supporting document retained by county treasurer. All supporting documents, except those submitted pursuant to subrule 400.3(17), shall be retained by the county treasurer.

This rule is intended to implement Iowa Code sections 321.20, 321.23, 321.24, 321.30, 321.31, 321.45 to 321.50, 321.67, 321.515, 321.519, 322.3 and 633A.4604.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 5893C, IAB 9/8/21, effective 10/13/21; ARC 6219C, IAB 3/9/22, effective 4/13/22]

761—400.5(321) Where to apply for registration or certificate of title.

400.5(1) Except as otherwise provided, application for the registration of a vehicle or a certificate of title for a vehicle, or transfers thereof, shall be made to the county treasurer as described in Iowa Code chapter 321. When none of the primary users of a non-resident-owned vehicle are located in Iowa, the vehicle may be registered by the county treasurer of any county.

400.5(2) Application shall be made to the department’s vehicle and motor carrier services bureau for the following:

a. Titling and registration of vehicles owned by the government. This requirement does not apply to manufactured or mobile homes subject to a public bidder sale as explained in Iowa Code subsection 321.46(2).

b. Registration of vehicles leased by the government for a period of 60 days or more.

c. Registration of urban and regional transit system buses.

d. Registration of fire trucks not owned and operated for a pecuniary profit.

e. Registration of certain authorized emergency vehicles owned and operated by nonprofit organizations.

f. Registration of private school buses.

g. Registration of vehicles under the provisions of Iowa Code subsection 321.23(4), relating to restricted-use vehicles.

400.5(3) Application for a certificate of title for a vehicle subject to apportioned registration under Iowa Code chapter 326 may be made to either the county treasurer or to the department's vehicle and motor carrier services bureau.

400.5(4) Application for apportioned registration shall be made to the department's vehicle and motor carrier services bureau. See 761—Chapter 500.

This rule is intended to implement Iowa Code sections 321.18 to 321.23, 321.46(2), and 321.170. [ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.6(17A) Addresses, information and forms. Assistance under this chapter is available as follows:

400.6(1) Information and forms for vehicle registration, certificate of title, or other procedures covered under Iowa Code sections 321.18 to 321.173 may be obtained from the county treasurer or by mail from the Vehicle and Motor Carrier Services Bureau, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3264; or on the department's website at www.iowadot.gov.

400.6(2) Information for investigations under this chapter may be obtained from the Bureau of Investigation and Identity Protection, Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3050; or on the department's website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3. [ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.7(321) Information appearing on title or registration. In addition to the requirements of Iowa Code sections 321.24, 321.52, 321.69, 321.71 and 322G.12, a certificate of title or registration receipt or both shall contain the following information when applicable:

- 400.7(1)** Registration expiration date.
- 400.7(2)** Registration month, as explained in rule 761—400.3(321).
- 400.7(3)** Name and address of last titled owner.
- 400.7(4)** Description of the vehicle, including the following items. These items may be represented on the title and registration by code letters or numbers.
 - a. Vehicle identification number.
 - b. Type, such as automobile, trailer, truck, etc.
 - c. Style.
 - d. Make, model, and model year.
 - e. Number of engine cylinders.
 - f. Color.
 - g. Weight and registered gross weight.
 - h. The square footage of floor space of a manufactured or mobile home or travel trailer, as determined by measuring the exterior.
 - i. The odometer mileage and whether the mileage is "actual," "not actual," or "exceeds mechanical limits."
- 400.7(5)** Previous Iowa title number or the name of the foreign jurisdiction if the previous title is a foreign title.
- 400.7(6)** Plate number and previous registration number.
- 400.7(7)** List price or value.
- 400.7(8)** Penalties and title, registration and security interest receipt numbers.
- 400.7(9)** The following phrase stamped on the reassignment portion of a manufactured or mobile home title: "Dealer reassignment not authorized on this certificate of title."

400.7(10) The designation required by 761—Chapter 405. A vehicle may have no more than one designation. The referenced rules explain which designation takes precedence when more than one designation could apply.

400.7(11) Full legal name of owner.

a. When the name of an owner changes from that which is printed on the title or registration issued to the owner, the owner shall submit to the county treasurer one of the following documents:

(1) Court order for a name change. The court order must contain the full name, date of birth, and court seal.

(2) Divorce decree.

(3) Marriage certificate.

b. This subrule does not apply to owners that are firms, associations, corporations, or trusts.

c. When the name of an owner changes from that which is printed on the registration card, the owner shall apply for a replacement registration card.

400.7(12) Driverless-capable vehicle indicator, which may also indicate whether operational restrictions exist.

This rule is intended to implement Iowa Code sections 321.24, 321.31, 321.40, 321.45, 321.52, 321.69, 321.71, 321.124, 321.515, 321.519 and 322G.12.

[ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5893C, IAB 9/8/21, effective 10/13/21]

761—400.8(321) Release form for cancellation of security interest.

400.8(1) A secured party may use a form prescribed by the department to note the cancellation of a security interest.

400.8(2) The secured party may also note the cancellation in a statement written on the secured party's letterhead if the statement is notarized and contains the following information: county that issued the title; title number; security interest number; vehicle identification number; vehicle owner's name; secured party's name, street address, city, state and ZIP code; date the security interest was canceled; and signature of an authorized representative of the secured party.

400.8(3) The secured party shall forward the original cancellation form or statement to the department or to the county treasurer of the county where the title was issued. Facsimiles and photocopies are not acceptable.

400.8(4) The secured party shall note the cancellation on the face of the title, attach a copy of the release form to the title as evidence of cancellation, and forward the title to the next secured party or, if there is no other secured party, to the person designated by the owner or, if there is no person designated, to the owner.

This rule is intended to implement Iowa Code section 321.50.

[ARC 4343C, IAB 3/13/19, effective 4/17/19]

761—400.9(321) Security interest notation, 30-day limit. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.10(321) Assignment of security interest. A security interest noted on a certificate of title may be assigned to another secured party without losing the seniority of the security interest by complying with the procedure in Iowa Code section 321.50 or with the following procedure:

400.10(1) Notice of assignment. The secured party listed on the title certificate shall make the following notation in the cancellation portion of the certificate of title where security interest is noted "Assigned to (name of assignee)." The date, name of secured party and signature of the person noting the assignment shall be completed in the cancellation portion pertaining to the security interest.

400.10(2) Application for notation of security interest. The assignee shall complete an application for notation of a security interest on the form provided by the department. The application form shall be signed by the assignee in the space where the signature of the owner is ordinarily required. The signature of the owner shall not be required on an assignment of a security interest.

400.10(3) *Submission of documents to county treasurer.* The certificate of title, application for notation of security interest and appropriate notation fee shall be submitted to the county treasurer of the county where the certificate of title was issued or will be issued.

a. If there are additional security interests noted on the certificate of title, the seniority of the assignee's security interest may be preserved by issuance of a certificate of title in lieu of the original, on which the assignee's security interest shall be noted in the same seniority as the assignor's.

b. A receipt for notation of security interest form shall be processed and the new receipt number shall be listed in the appropriate space provided. The original notation date shall also be listed and the words "by assignment" shall be listed following the name of the assignee.

This rule is intended to implement Iowa Code section 321.50.

761—400.11(321) Sheriff's levy, restitution lien, and forfeiture lien noted as security interests.

400.11(1) A sheriff's levy may be noted as a security interest on a certificate of title if the sheriff so desires. To apply for a notation of a security interest, the sheriff or the sheriff's deputy shall complete an application form prescribed by the department. The sheriff or sheriff's deputy shall sign the application in the space where the signature of the owner is ordinarily required. The signature of the owner is not required. The appropriate notation fee shall be submitted with the application form to the county treasurer of the county where the certificate of title was issued. If the certificate of title is not surrendered with the application, the county treasurer shall notify the holder of the certificate of title in the manner prescribed in Iowa Code section 321.50.

400.11(2) A restitution or forfeiture lien may be noted as a security interest on a certificate of title if the county attorney so desires. To apply for a notation of a security interest, the county attorney or designee shall complete an application form prescribed by the department. The county attorney or designee shall sign the application in the space where the signature of the owner is ordinarily required. The signature of the owner is not required. A lien notation fee is not required. If the certificate of title is not surrendered with the application, the county treasurer shall notify the holder of the certificate of title in the manner prescribed in Iowa Code section 321.50.

This rule is intended to implement Iowa Code section 321.50 and chapter 809A.
[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.12(321) Replacement certificate of title.

400.12(1) When a certificate of title is lost, destroyed or altered, the owner or lienholder shall apply for a replacement certificate of title. If a security interest noted on the certificate of title was released by the secured party on a separate form, but the secured party has not delivered the original certificate of title to the appropriate party, the owner may apply for a replacement certificate of title as provided in Iowa Code section 321.42.

400.12(2) Application for a replacement certificate of title shall be made on a form prescribed by the department. All owners of the vehicle as listed on the certificate of title shall sign the application form. If an owner is deceased, the signatures and documents specified in subrules 400.14(4) and 400.14(5) shall be required in lieu of the deceased owner's signature. A person entitled to vehicle ownership under the laws of descent and distribution shall sign the required forms and shall insert the words "heir at law" following the signature.

This rule is intended to implement Iowa Code section 321.42.

761—400.13(321) Bond required before title issued. An applicant for a certificate of title who cannot provide the supporting documents required in rule 761—400.4(321) shall be required to file a bond as a condition to obtaining a title and registration plates.

400.13(1) *Procedures.* This subrule describes the procedures to be followed to obtain a "bonded" certificate of title. The procedures described are in addition to the regular procedures for titling and registering a vehicle.

a. The applicant shall submit a bond application to the vehicle and motor carrier services bureau on a form prescribed by the department. The application shall be accompanied by evidence of ownership of the vehicle.

b. The department shall search the state files to determine if there is an owner of record for the vehicle and if the vehicle has been reported stolen or embezzled.

(1) If a record is found, the applicant shall complete a request for release of personal information form explaining that the applicant is the current owner and is requesting a duplicate title. The department shall mail the release by first-class mail to the owner of record, at the owner's last-known address.

(2) If the department receives no response from the owner of record within ten days after the date of mailing or the owner of record does not want the owner's personal information released, the department will continue processing the bond application.

c. If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall determine the current value of the vehicle and notify the applicant to deposit cash or file a surety bond with the department in an amount equal to one and one-half times the current value of the vehicle.

d. After the cash deposit or surety bond has been deposited, a motor vehicle investigator of the department may examine the vehicle to verify the information submitted on the application is correct. The owner of the vehicle may drive or tow the vehicle to and from the examination location after completing an affidavit to drive on a form provided by the department. The form shall state that the vehicle is reasonably safe for operation, and the form must be signed by the owner. After verifying the information, the investigator shall authorize the county treasurer to issue a title for and register the vehicle. Should the vehicle not meet the equipment requirements of Iowa Code chapter 321, the investigator shall authorize the county treasurer to issue a title and registration but instruct the county treasurer to immediately suspend the registration until such time as the vehicle meets these equipment requirements. If applicable, the investigator shall also affix an assigned vehicle identification number to the vehicle.

e. The applicant shall then make application for a certificate of title and registration.

400.13(2) Disapproval. If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, or that there is an unsatisfied security interest, then the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

400.13(3) Junked vehicle. A certificate of title shall not be reinstated for a vehicle that has been issued a junking certificate unless the junking certificate was issued in error, as explained in rule 761—400.23(321), or the vehicle qualifies as an antique vehicle under Iowa Code subsection 321.115(1).

This rule is intended to implement Iowa Code sections 321.24 and 321.52.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.14(321) Transfer of ownership. The following procedures shall apply for all titling and registration purposes:

400.14(1) Transfer of vehicle owned by two or three persons.

a. If the names of the owners of a vehicle on the certificate of title or on the manufacturer's certificate of origin are joined by the word "or," as in "John Doe, Jane Doe or Mary Doe," then the signature of any of these owners is sufficient to transfer title or to junk the vehicle.

b. If ownership of a vehicle is stated as a name or names followed by the words "Doing Business As" or the initials "DBA" and another name, only the name of an owner followed by the signature of an authorized representative of an owner is required to transfer title or to junk the vehicle.

EXAMPLE: Ownership is stated as "John Smith and Mary Smith DBA Smith Repair." Jane Doe is an authorized representative of John Smith and Mary Smith. To transfer ownership, Jane Doe may sign as

“John Smith and Mary Smith DBA Smith Repair, by Jane Doe,” “John Smith and Mary Smith by Jane Doe,” or Smith Repair by Jane Doe.”

c. In all other cases the signature of each named owner is required.

400.14(2) *Assignment of title to two or three persons.* If a certificate of title or a manufacturer’s certificate of origin is assigned to two or three persons with their names joined by the word “or,” as in “John Doe, Jane Doe or Mary Doe,” then a certificate of title may be issued to any one of these persons, or to any two or all three of these persons with their names joined by the word “or.” However, a certificate of title shall only be issued to persons who have signed the application for title.

400.14(3) *Organizational ownership.*

a. When a vehicle is owned by a partnership, corporation, association, governmental unit, or private organization, the signature of its authorized representative is required.

b. When a vehicle is owned by a trust, the title shall be accompanied by a copy of all documents creating or otherwise affecting the trust or by the certification of trust as defined in Iowa Code section 633A.4604.

(1) The certification of trust may be signed by any trustee or the attorney for any trustee.

(2) The title shall be signed by the number of trustees as specified in the trust agreement, and the transferor shall provide the department with the document or the certification of trust specifying the required signatories for the trust.

(3) If a certification of trust is provided, one of the following shall apply:

1. Any currently acting trustee may sign the title if the certification of trust states that such trustee may act individually.

2. A majority of the trustees must sign the title if the certification of trust states that the trustees must act by majority decision.

3. All currently acting trustees must sign the title if the certification of trust states that the trustees must act by unanimous decision.

(4) A certification of trust must meet the requirements of Iowa Code section 633A.4604, including but not limited to providing the names of all the currently acting trustees. If there are two or more currently acting trustees, the certification of trust must state whether the trustees may act individually, whether the trustees must act by majority decision or whether the trustees must act by unanimous decision. If the certification of trust does not meet said requirement, the certification of trust will be considered invalid for the purposes of the transfer.

(5) Each signature on the title shall be followed by the words “as trustee.”

400.14(4) *Death with a will.* When ownership is transferred according to a decedent’s will, a certified copy of the court order or the letter of appointment appointing the person assigning the title as executor of the will shall be required.

400.14(5) *Death without a will.* When ownership is transferred from a decedent without a will and there is no administration of the estate, an affidavit of death intestate form signed by the clerk of court shall be required. When ownership is transferred from a decedent without a will but there is an administration of the estate, a copy of the court order or the letter of appointment appointing the person assigning the title as administrator shall be required.

400.14(6) *Power of attorney.* An attorney in fact may act for the owner(s) if the appointment is shown on a power of attorney form. Power of attorney forms are available from the department but other forms may be accepted if they contain all necessary information. The power of attorney form or a certified true copy shall be kept by the county treasurer and attached to the document to which it applies.

This rule is intended to implement Iowa Code sections 321.20, 321.24, 321.45, 321.47, 321.49, 321.67 and 633A.4604.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 6219C, IAB 3/9/22, effective 4/13/22]

761—400.15(321) Cancellation of a certificate of title.

400.15(1) The department shall cancel a certificate of title when authorized by any provision of law or when it has reasonable grounds to believe that the title has not been surrendered to the county treasurer

as provided in Iowa Code section 321.52 or when the vehicle has been stolen or embezzled from the rightful owner or seized under the provisions of Iowa Code section 321.84, and the person holding the certificate of title, purportedly issued for the vehicle, has no immediate right to possession of the vehicle.

400.15(2) The decision to issue a new certificate of title or to allow the previous title to be reinstated through a replacement title application process or to take any other action regarding ownership of the vehicle for which the current title has been canceled shall be determined after an investigation and recommendation by a motor vehicle investigator of the department.

This rule is intended to implement Iowa Code section 321.101.

761—400.16(321) Application for certificate of title or original registration for a specially constructed, reconstructed, street rod or replica motor vehicle.

400.16(1) *Definitions applicable to this rule.*

a. “*Ownership document for the vehicle*” means the certificate of title, the manufacturer’s certificate of origin, the junking certificate, or other evidence of ownership acceptable to the department.

b. “*Ownership documents for essential parts*” means bills of sale for all essential parts used to construct or reconstruct the vehicle. Each bill of sale shall contain a description of the part, the manufacturer’s identification number of the part, if any, and the name, address, and telephone number of the seller.

400.16(2) *Procedures.* This subrule describes the procedures for obtaining department approval to title and register a specially constructed, reconstructed, street rod or replica motor vehicle. The procedures described are in addition to the regular procedures for titling and registering a vehicle.

a. The applicant shall apply to the county treasurer for a certificate of title and registration. The county treasurer, upon receiving an application that indicates the vehicle is a specially constructed, reconstructed, street rod or replica motor vehicle, shall forward the application to a motor vehicle investigator of the department.

b. The investigator shall contact the applicant and schedule a time and place for an examination of the vehicle and the ownership documents. The owner of the vehicle may drive or tow the vehicle to and from the examination location by completing an affidavit to drive on a form provided by the department. The form shall state that the vehicle is reasonably safe for operation and must be signed by the owner. The applicant, when appearing with the vehicle for the examination, shall submit to the investigator the ownership document for the vehicle, the ownership documents for essential parts, and a weigh ticket indicating the weight of the vehicle. However, a weigh ticket is not required for motorcycles, autocycles, trucks, truck tractors, road tractors or trailer-type vehicles.

c. If the investigator determines that the vehicle complies with 761—Chapter 450, that the integral parts and components have been identified as to ownership, and that the application has been completed properly:

(1) The investigator shall approve the application, affix to the vehicle an assigned vehicle identification number, and return the application and ownership documents to the applicant. The investigator shall authorize the county treasurer to issue a title and registration for the vehicle.

(2) If the vehicle is a passenger-type motor vehicle, the department shall determine its weight and value. The department shall also determine if the vehicle is subject to the electric vehicle annual registration fee. The vehicle weight shall be fixed at the next even 100 pounds above the actual weight of the vehicle fully equipped, as provided in Iowa Code section 321.162. The weight and value shall constitute the basis for determining the annual registration fee under Iowa Code section 321.109, except as provided in Iowa Code section 321.113.

(3) The applicant shall then submit the ownership document for the vehicle to the county treasurer and continue with the regular title and registration process.

400.16(3) *Disapproval.* If the department determines that the vehicle does not comply with 761—Chapter 450, that the integral parts or components have not been identified as to ownership, or that the application has not been completed properly, then the department shall not approve the vehicle for titling and registration.

400.16(4) Model year. The model year of a specially constructed or reconstructed motor vehicle is the year the vehicle is approved by the department as a specially constructed or reconstructed motor vehicle.

This rule is intended to implement Iowa Code sections 321.20, 321.23, 321.24, 321.52, 321.109, 321.116, 321.117 and 321.162.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5178C, IAB 9/9/20, effective 10/14/20]

761—400.17(321) Remanufactured vehicle. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.18(321) Rescinded IAB 3/26/97, effective 4/30/97.

761—400.19(321) Temporary use of vehicle without plates or registration card.

400.19(1) Temporary use of vehicle without plates. A person who acquires a vehicle which is currently registered or in a dealer's inventory at the time of sale and who does not possess registration plates which may be assigned to and displayed on the vehicle may operate or permit the operation of the vehicle not to exceed 30 days from the date of purchase or transfer without registration plates displayed thereon, if ownership evidence is carried in the vehicle.

400.19(2) Temporary use of vehicle without registration card. A person who acquires a vehicle which is currently registered or in a dealer's inventory at the time of sale and who has possession of plates which may be attached to the vehicle acquired may operate or permit the operation of the vehicle not to exceed 45 days from the date of purchase or transfer without a registration card, if ownership evidence is carried in the vehicle.

400.19(3) Ownership evidence. Ownership evidence under this rule shall consist of the certificate of title or registration receipt, or a photocopy thereof, properly assigned to the person who has acquired the vehicle, or a bill of sale conveying ownership of the vehicle to the person who has acquired the vehicle. The ownership evidence shall be shown to any peace officer upon request.

This rule is intended to implement Iowa Code sections 321.25, 321.33 and 321.46.

761—400.20(321) Registration of motor vehicle weighing 55,000 pounds or more. When applying for registration or renewal of registration for a motor vehicle weighing 55,000 pounds or more, the owner shall present to the department or to the county treasurer proof of compliance with the federal heavy vehicle use tax required by 26 U.S.C. Section 4481 and 26 CFR Part 41.

400.20(1) If the motor vehicle is used exclusively in the transportation of harvested forest products, the owner may present a written statement certifying that usage and the usage will be recorded.

400.20(2) If the motor vehicle is used primarily for farming purposes, the owner may present a written statement certifying that usage and the usage will be recorded.

This rule is intended to implement Iowa Code sections 307.30 and 321.20.

761—400.21(321) Registration of vehicles on a restricted basis. The department may register a vehicle which does not meet the equipment requirements of Iowa Code chapter 321, due to the particular use for which it is designed or intended, or which is a driverless-capable vehicle as defined in rule 761—380.2(321). Registration may be accomplished upon payment of the appropriate fees and after inspection and certification by the department that the vehicle is not in an unsafe condition.

400.21(1) Operation of the vehicle may be restricted to a roadway to which a specific lawful speed limit applies, as specified in Iowa Code section 321.285, if the maximum speed of the vehicle is such that the operation of the vehicle would impede or block the normal and reasonable movement of traffic.

400.21(2) The department may also restrict the operation of the vehicle to daylight hours if operation of the vehicle during hours other than daylight would create a hazard.

400.21(3) A certificate of restriction shall be issued in conjunction with registration of the vehicle, listing the restrictions that apply to the operation of the vehicle.

a. Registration laws applicable to motor vehicles in general shall also apply to vehicles registered under a restricted registration.

b. The department may approve exceptions to those equipment requirements of Iowa Code chapter 321 which cannot be met due to the particular use for which the vehicle is designed or intended.

400.21(4) The department shall not register an all-terrain vehicle. The department shall not register a vehicle built on or after January 1, 1968, unless it was manufactured primarily for use on public streets, roads and highways except a vehicle operated exclusively by a person with a disability, which may be registered if the department, in its discretion, determines that the vehicle is not in an unsafe condition. This subrule does not apply to a specially constructed, reconstructed, street rod or replica motor vehicle as defined in Iowa Code section 321.1.

400.21(5) When a vehicle registered in this state is modified to make it a driverless-capable vehicle as defined in rule 761—380.2(321), the person in whose name the vehicle is registered shall within 30 days notify the department upon a form prescribed by the department.

400.21(6) As provided in Iowa Code sections 321.515 and 321.519, the department may restrict the operations of a driverless-capable vehicle registered in this state or another state but which operates in this state. The restrictions may include but are not limited to the restrictions provided in subrules 400.21(1) and 400.21(2) and any operational restrictions based on a specific functional highway classification, weather conditions, days of the week, times of day, and other elements of operational design while the automated driving system is engaged. The department may require the vehicle owner to submit to the department the automated driving system's intended operational design domain for the vehicle on a form prescribed by the department. The department may evaluate the automated driving system's intended operational design domain for the vehicle. The department may establish additional operational restrictions to ensure safe operation of the vehicle. The department shall issue a certificate of restriction as provided in subrule 400.21(3) for any restriction established under this subrule, and the certificate shall be carried in the vehicle and made available for inspection by any peace officer upon request.

This rule is intended to implement Iowa Code sections 321.1, 321.23(4), 321.30(2), 321.101(1), 321.234A, 321.515 and 321.519.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 5893C, IAB 9/8/21, effective 10/13/21]

761—400.22(321) Transfers of ownership by operation of law. When ownership of a vehicle is transferred by operation of law under Iowa Code section 321.47, the following, in addition to rule 761—400.4(321), shall apply:

400.22(1) The new certificate of title and registration shall be issued, upon receipt of the proper documentation, by the county treasurer of the county where the transferee resides.

400.22(2) If the vehicle is not currently registered in this state, the registration fee and penalties due shall be computed in accordance with the following:

a. If the vehicle is ordered confiscated or forfeited by a court under a judgment or forfeiture, the fee shall be computed on the remaining unexpired months in the registration year from the date of the court order.

b. If the vehicle is sold on a peace officer's bill of sale as an unclaimed, stolen, embezzled or abandoned vehicle, or as a vehicle seized under Iowa Code section 321.84, the fee shall be computed on the remaining unexpired months in the registration year from the date of the sale.

c. If the vehicle is sold or transferred under a judgment or order entered by a court in a civil action or proceeding, or is transferred under any provision of Iowa Code section 321.47 which is not covered in this subrule, the fee shall include any delinquent fees which have accrued during previous registration periods and accrued penalties. Penalties shall continue to accrue until paid.

d. If the vehicle was last titled or registered in a foreign state, the fee shall be based on the month the vehicle becomes subject to registration in this state, except as provided in paragraphs 400.22(2) "a" and "b" above.

This rule is intended to implement Iowa Code sections 321.47, 321.105, 321.106, 321.134, and 321.135.

761—400.23(321) Junked vehicle.

400.23(1) Junking certificate. The owner of a vehicle that is to be junked or dismantled shall obtain a junking certificate in accordance with Iowa Code subsection 321.52(3).

400.23(2) Retitling a junked vehicle. The department may authorize issuance of a new certificate of title to the vehicle owner named on the junking certificate only if the department determines that the junking certificate was issued in error.

a. The reasons a junking certificate was issued in error include but are not limited to the following:

(1) The owner inadvertently surrendered the wrong certificate of title. The owner shall submit to the department a photocopy of the ownership document for each vehicle and a signed statement explaining the circumstances that resulted in the error.

(2) A junking certificate was obtained in error and the vehicle continues to be registered. The owner shall submit to the department a photocopy of the current registration and a signed statement explaining the circumstances that resulted in the error.

(3) The owner intended to apply for a salvage title under Iowa Code subsection 321.52(4) but inadvertently submitted an application for a junking certificate. The owner shall submit to the department a bill of sale or other documentation from the previous owner stating that the vehicle was rebuildable when purchased and a signed statement explaining the owner's original intention to obtain a salvage title. The department shall inspect the vehicle to verify the rebuildable condition.

b. If the department determines that the junking certificate was issued in error, the department shall authorize the proper county treasurer to issue a certificate of title for the vehicle after payment by the owner of appropriate fees and taxes, including the return of any credit or refund for registration fees paid to the owner because of the error.

c. If the department determines that the junking certificate was not issued in error and denies the application for reinstatement of the certificate of title for the vehicle, the owner may apply for a certificate of title under the bonding procedure in rule 761—400.13(321) if the vehicle qualifies as an antique vehicle under Iowa Code subsection 321.115(1).

This rule is intended to implement Iowa Code subsection 321.52(3).

761—400.24(321) New vehicle registration fee. The registration fee shall be computed on the month of purchase of a new vehicle, except that the registration fee on a new vehicle acquired outside of this state shall be based on the month that the vehicle was brought into Iowa.

This rule is intended to implement Iowa Code sections 321.105 and 321.135.

761—400.25(321) Fees established by the department. If the department cannot obtain the retail list price and weight for a particular motor vehicle model registered under Iowa Code subsection 321.109(1), the department shall determine a list price and weight.

This rule is intended to implement Iowa Code sections 321.109, 321.157 and 321.159.

761—400.26(321) Anatomical gift. Voluntary contributions collected by the county treasurer or the department to the anatomical gift public awareness and transplantation fund shall be in whole dollar amounts. The county treasurer and the department shall remit contributions collected to the department of public health quarterly.

This rule is intended to implement Iowa Code section 321.44A.

761—400.27(321,322) Vehicles held for resale or trade by dealers. A motor vehicle dealer, as defined in Iowa Code section 321.1, is authorized to hold a motor vehicle for resale or trade under the following conditions.

400.27(1) Assignment to dealer. The certificate of title or manufacturer's certificate of origin for the vehicle shall be assigned to the dealer by the seller. The seller shall complete the assignment portion of the form, including the date of sale or trade and the name and address of the dealer, and shall sign the form. The date of the sale or trade shown in the assignment portion of the form shall be the date the dealer acquired the vehicle.

400.27(2) New certificate of title and registration not required.

a. A motor vehicle currently registered in Iowa may be held by a dealer without obtaining a new certificate of title or a new registration if the dealer holds for that vehicle a certificate of title or a manufacturer's certificate of origin properly assigned to the dealer.

b. A motor vehicle may also be held by a dealer without obtaining a new certificate of title or a new registration if the dealer has a title from a state that permits its titles to be reassigned by Iowa dealers and if a vacant reassignment space is available on the title.

400.27(3) *New certificate of title required.* A dealer shall obtain a new certificate of title, but is not required to pay registration fees for a vehicle if:

a. The vehicle has been registered in a foreign state or country that does not permit its titles to be reassigned by Iowa dealers.

b. The vehicle was assigned to the dealer using an affidavit of foreclosure form prescribed by the department or issued by a foreign jurisdiction.

c. The reassignment area of the certificate of title has been used.

d. Reserved.

e. The vehicle registration fee was delinquent in Iowa at the time the vehicle was acquired by the dealer. The delinquent fees and penalty shall be paid by the dealer from the first day the registration was due to the month the application for title is submitted.

f. In accordance with 761—Chapter 405, the dealer is required to obtain a salvage certificate of title.

400.27(4) *New certificate of title and registration fee required.* A dealer shall obtain both a new certificate of title and pay a registration fee for a vehicle if:

a. The vehicle has a foreign certificate of title but has never been registered and the dealer is not licensed under Iowa Code chapter 322 to sell that line-make of vehicle. The registration fee due shall be prorated for the remaining unexpired months of the dealer's registration year.

b. The vehicle was placed in storage by the previous owner. The registration fee due shall be a full registration year fee.

c. The vehicle has been registered in a foreign state or country that does not permit its titles to be reassigned by Iowa dealers or all reassignment spaces on the title are full and the application for a new certificate of title is submitted more than 30 days after the date the vehicle entered Iowa. The registration fee due shall be prorated for the remaining unexpired months of the dealer's registration year.

d. The vehicle was in the dealer's inventory and the dealer's license was revoked as provided in Iowa Code chapter 322 or 322C or surrendered in lieu of revocation. The dealer shall obtain title and registration within 30 days from the date of revocation or surrender of the license. The registration fee due shall be prorated for the remaining unexpired months of the registration year.

400.27(5) *Registration fee required.* A vehicle owned by a dealer and used as a work or service vehicle, or offered for lease, rent or hire, shall become subject to a registration fee in the month that the vehicle is first used for that purpose. The registration fee shall be due annually unless the vehicle is transferred to the dealer's inventory. To transfer the vehicle, the dealer shall surrender the registration plates that were issued for the vehicle.

400.27(6) *Violations.*

a. Failure to comply with this rule is a violation of Iowa Code subsection 321.104(2).

b. Failure to obtain a certificate of title when required shall result in a title penalty of \$10, as specified in Iowa Code subsection 321.49(1).

This rule is intended to implement Iowa Code sections 321.45, 321.46, 321.48, 321.49, 321.67, 321.70, 321.104 and chapter 322.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.28(321) Special trucks. The owner of a truck tractor registered as a special truck shall certify to the owner's county treasurer annually at the time of renewal that the truck tractor is not operated more than 15,000 miles annually.

This rule is intended to implement Iowa Code sections 321.1(75) and 321.121.

[ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.29(321) Vehicles previously registered under Iowa Code chapter 326. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.30(321) Registration of vehicles registered in another state or country.

400.30(1) The registration fee for a vehicle from another state or country shall be due in the month that the vehicle becomes subject to registration in Iowa.

400.30(2) A vehicle registered in another state or country shall become subject to registration in Iowa and payment of the Iowa registration fee in:

a. The month of sale or transfer to an Iowa resident, or

b. The month that a nonresident owner establishes Iowa residency or accepts employment in Iowa of 90 days duration or longer. The county treasurer or the department may require from the applicant a written statement giving the date that the applicant established residency in Iowa.

400.30(3) Rescinded IAB 2/6/02, effective 3/13/02.

This rule is intended to implement Iowa Code sections 321.18, 321.20, 321.53 to 321.55, 321.101 and 321.135.

761—400.31 Rescinded, effective 12/1/83.

761—400.32(321) Vehicles owned by nonresident members of the armed services.

400.32(1) A vehicle owner who is a nonresident and a member of the armed services shall not be required to register the vehicle in Iowa if it is properly registered in the person's state of residence.

400.32(2) A vehicle owner who is a nonresident and a member of the armed services may register the vehicle in Iowa under the following conditions:

a. The vehicle is owned entirely by nonresidents.

b. The fee for a passenger-type vehicle registered under Iowa Code section 321.109 shall be based only on the weight of the vehicle; the part of the fee based on value shall be excluded. The fees for all other vehicles shall be determined as specified in Iowa Code chapter 321. The registration fee under Iowa Code sections 321.116 and 321.117 shall apply.

c. The application for vehicle registration shall include a certification by the person's commanding officer of the person's state of residence and assignment to Iowa.

400.32(3) If ownership of a passenger-type vehicle is transferred to another person, the vehicle shall be subject to registration in Iowa.

This rule is intended to implement Iowa Code sections 321.53 to 321.55, 321.109, 321.116 and 321.117.

[ARC 5178C, IAB 9/9/20, effective 10/14/20]

761—400.33(321) Disabled veterans exemption from payment of registration fees. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.34(321) Multipurpose vehicle registration fee. Rescinded IAB 11/7/07, effective 12/12/07.

761—400.35(321) Registration of vehicles equipped for persons with disabilities. The registration fee shall be reduced for an automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less with permanent equipment for assisting a person with a disability or for an automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less used by a person who uses a wheelchair as the person's only means of mobility. To qualify for the reduction, the owner of the vehicle must provide a written self-certification at the first registration and at each renewal:

400.35(1) That the automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less has permanently installed equipment manufactured for and necessary to assist a person with a disability, as defined in Iowa Code section 321L.1, to enter or exit the vehicle, or

400.35(2) That the owner or a member of the owner's household uses a wheelchair as the person's only means of mobility.

This rule is intended to implement Iowa Code sections 321.109, 321.124 and 321L.1.
[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.36(321) Land and water-type travel trailers registration fee. The registration fee for trailer-type vehicles designed to be used as a travel trailer and for use upon water shall be registered as a travel trailer. The exterior measurements used to determine the registration fee shall not include any pen deck area or area occupied by a trailer hitch.

This rule is intended to implement Iowa Code sections 321.1 and 321.123.

761—400.37(321) Motorcycle or autocycle primarily designed or converted to transport property. A motorcycle or autocycle primarily designed or converted to transport less than 1000 pounds of property shall be registered as a motorcycle or autocycle. A motorcycle or autocycle primarily designed or converted to transport 1000 pounds of property or more shall be registered as a motor truck.

This rule is intended to implement Iowa Code sections 321.1 and 321.117.
[ARC 2985C, IAB 3/15/17, effective 4/19/17]

761—400.38(321) Rescinded IAB 3/26/97, effective 4/30/97.

761—400.39(321) Conversion of motor vehicles.

400.39(1) An automobile converted to a truck with a carrying capacity of 1000 pounds or more shall be registered as a reconstructed motor vehicle.

400.39(2) A vehicle manufactured as a truck tractor or motor truck shall not be registered as a motor home unless the vehicle has been substantially altered to change its type and mode of operation so that it is a reconstructed vehicle as defined in Iowa Code section 321.1.

This rule is intended to implement Iowa Code sections 321.23, 321.111 and 321.124.
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.40(321) Manufactured or mobile home converted to or from real property.

400.40(1) Conversion to real property. When a manufactured or mobile home is converted to real property under Iowa Code section 435.26, the assessor shall collect its vehicle certificate of title. The assessor shall note the conversion on the face of the certificate of title above the assessor's signature, date the notation and deliver the title to the county treasurer. The county treasurer shall note the conversion on the vehicle record and then cancel and retain the certificate of title.

400.40(2) Reconversion from real property.

a. When a manufactured or mobile home is reconverted from real property by adding a vehicular frame, the owner may apply to the county treasurer for a certificate of title.

b. The owner shall submit a record of existing liens obtained from a local abstractor. The record shall identify the owner of the property, list all liens and encumbrances against the property, and shall be signed by the abstractor.

c. The owner shall also submit written consent to the reconversion from any person holding a mortgage on the real property (mortgagee). An existing mortgage shall be noted as a security interest on the certificate of title.

d. The county treasurer shall submit written notice of the reconversion to the county assessor's office.

This rule is intended to implement Iowa Code sections 321.1, 435.1, 435.26, 435.26A and 435.27.
[ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.41(321) Special registration plates. Rescinded IAB 3/1/95, effective 4/5/95.

761—400.42(321) Church bus registration fee. The church bus registration fee shall not apply if the bus is used in a manner other than provided by law or if ownership of the bus is transferred to a person who is not entitled to register the vehicle as a church bus.

400.42(1) When the church bus registration fee does not apply, the bus shall be registered under the provisions of Iowa Code section 321.122.

400.42(2) When Iowa Code section 321.122 applies and the bus is currently registered as a church bus, the registration fee shall be prorated for the remaining unexpired months of the registration year.

This rule is intended to implement Iowa Code sections 321.119 and 321.122.

761—400.43(321) Storage of vehicles.

400.43(1) The owner of a vehicle upon which the registration fee is not delinquent may surrender all registration plates for the vehicle to the county treasurer where the vehicle is registered and shall have the right to register the vehicle later upon payment of the annual registration fee due at the time of removal of the vehicle from storage. Payment of a registration fee shall not be required when the vehicle is removed from storage within the current registration year provided that registration fees have not been refunded. Plates that have been surrendered shall be destroyed. When a vehicle is removed from storage, the fee is \$5 for a set of replacement plates.

400.43(2) The owner of a motor vehicle which is placed in storage when the owner enters the military service of the United States shall comply with Iowa Code section 321.126, and subrule 400.43(1) does not apply.

This rule is intended to implement Iowa Code sections 321.126 and 321.134.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.44(321) Penalty on registration fees.

400.44(1) Monthly basis. The penalty on the delinquent payment of a registration fee shall be computed on a monthly basis, rounded to the nearest whole dollar. If multiple penalties are assessed, the penalties shall be first added together and then the sum shall be rounded to the nearest whole dollar.

400.44(2) Vehicle purchased. The penalty on the registration fee shall accrue from the first day of the month following the date of purchase, unless the application for a certificate of title is submitted within 30 days after the date of purchase.

400.44(3) Vehicle moved into Iowa. The penalty on the registration fee shall accrue on the first day of the month following 30 days from the date a vehicle is moved into Iowa.

400.44(4) When delinquency extends beyond the current year. When the penalty on a delinquent registration fee extends beyond the current year, the penalty shall continue to accrue until paid. Penalty shall only accrue on the fee applicable at the time the delinquency accrued and shall not be applicable to subsequent registration fees which have not been paid.

400.44(5) Statement of nonuse. If the owner of a vehicle, on which the registration fees have not been paid for more than three complete registration years, certifies to the county treasurer of the owner's residence that the vehicle has not been moved or operated upon the highway since the year it was last registered, the county treasurer may register the vehicle upon payment of the current year's registration fee.

400.44(6) Waiver of penalties for military members. Registration penalties shall be waived as provided in Iowa Code section 321.134, subsection 5, if the owner provides a copy of an official government document verifying that the applicant is in the military service of the United States and has been relocated as a result of being placed on active duty on or after September 11, 2001.

This rule is intended to implement Iowa Code sections 321.39, 321.46, 321.47, 321.49, 321.134 and 321.135.

[ARC 5178C, IAB 9/9/20, effective 10/14/20]

761—400.45(321) Suspension, revocation or denial of registration.

400.45(1) The department shall suspend or revoke registration and plates under Iowa Code section 321.101 when a written request is received from a peace officer or the county treasurer's office that issued the registration and plates.

- a. A request from a peace officer shall be submitted on a form prescribed by the department.
- b. A request from a county treasurer's office shall be signed by the county treasurer or designee.

400.45(2) When the registration of a vehicle has been revoked as provided in Iowa Code sections 321.101 and 321.101A, the registration fee and penalty shall accrue as if the plates had never been issued, unless waiver of registration fees and penalties is specifically provided for in Iowa Code chapter 321.

400.45(3) In accordance with Iowa Code section 252J.8, the department shall suspend or deny the issuance or renewal of registration and plates upon receipt of a certificate of noncompliance from the child support recovery unit.

- a. The suspension or denial shall become effective 30 days after notice to the vehicle owner and continue until the department receives a withdrawal of the certificate of noncompliance from the child support recovery unit.

- b. If a person who is the named individual on a certificate of noncompliance subsequently purchases a vehicle, the vehicle shall be titled and registered, but the registration shall be immediately suspended.

This rule is intended to implement Iowa Code sections 252J.1, 252J.8, 252J.9, 321.101, 321.101A and 321.127.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4758C, IAB 11/6/19, effective 12/11/19]

761—400.46(321) Termination of suspension of registration. Upon termination of the suspension of registration of a vehicle, the county treasurer shall issue new plates for the vehicle. If the new plates replace a current series of plates, there shall be a replacement fee as provided in Iowa Code section 321.42. If the vehicle is not currently registered at the time the suspension is lifted, the registration fee and penalties due shall be determined as follows:

400.46(1) If the registration fee was delinquent at the time that the suspension became effective, the penalty shall continue to accrue on the registration fee until the suspension became lifted and the registration fee is paid. In addition, if the suspension was for failure to pay an additional registration fee, the additional registration fee shall be paid before the suspension is lifted.

400.46(2) If the registration fee was not delinquent when the suspension became effective and the suspension is lifted after the beginning of another registration year, the annual registration fee for that year shall be due in the month the suspension is lifted. The penalty shall accrue on the registration fee the first day of the month following the month that the suspension was lifted. The annual registration fee on a recovered stolen vehicle for which the registration has been suspended shall be prorated for the remaining unexpired months of the registration year.

400.46(3) If the registration fee was not delinquent at the time that the suspension became effective and the suspension is lifted during the same registration period, no additional registration fees shall be due unless the suspension was for failure to pay an additional registration fee, in which event the additional registration fee shall be paid before the suspension is lifted.

This rule is intended to implement Iowa Code sections 321.42, 321.105 and 321.134.

761—400.47(321) Raw farm products. A vehicle may be operated with a gross weight of 25 percent in excess of the gross weight for which it is registered when transporting a load of raw farm products or soil fertilizers under Iowa Code section 321.466 except that nothing in this rule shall be construed to allow operation of a special truck on the public highways with a gross weight exceeding the maximum gross weight allowed under Iowa Code section 321.463(6). In addition, the following products shall be considered raw farm products. This list shall not be deemed conclusive and shall not exclude other commodities which might be considered raw farm products:

Animals which are dead	Hides
Berries, fresh	Honey, comb or extracted
Blood	Melons
Corn, ear corn including hybrids	Milk, raw
Corn, shelled	Nursery stock
Corn, cobs	Potatoes
Cream, separated	Peat
Eggs, fresh or frozen in shell	Poultry, live
Flax	Saw logs
Flaxseed	Sod
Fodder	Soybeans
Fruit, fresh	Straw, baled or loose
Grain, threshed or unthreshed	Vegetables, fresh
Hair	Wood, cord or stove wood
Hay, baled or loose	Wool

This rule is intended to implement Iowa Code sections 321.466(4) and 321.466(5).
[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.48(321) Special mobile equipment. Rescinded IAB 3/7/90, effective 4/11/90.

761—400.49(321) Special mobile equipment transported on a registered vehicle. Rescinded IAB 3/7/90, effective 4/11/90.

761—400.50(321,326) Refund of registration fees.

400.50(1) Vehicles registered by county treasurer.

a. The department shall refund fees for vehicles registered by the county treasurer pursuant to Iowa Code section 321.126.

b. A claim for refund shall be made on a form prescribed by the department. Except as provided in Iowa Code section 321.126, the claim may be submitted to the county treasurer's office in any county.

c. Registration plates shall be submitted with the claim if the vehicle is placed in storage or registered for apportioned registration, if the owner of the vehicle moves out of state, or if the plates have not been assigned to a replacement vehicle. If one or both plates have been lost or stolen, the claimant shall certify this fact in writing.

d. For a vehicle that was junked, the date on the junking certificate shall determine the date the vehicle was junked.

e. If the claim for refund is for excess credit or no replacement vehicle:

(1) The county treasurer shall enter into the state motor vehicle computer system the information required to process the refund. The information shall be entered within three days of receipt of the claim for refund.

(2) The claim for refund shall be approved or denied by the vehicle and motor carrier services bureau.

f. All other claims for refund shall be forwarded to the vehicle and motor carrier services bureau for processing.

400.50(2) Vehicles registered by department. Forms and instructions for claiming a refund on apportioned registration fees under Iowa Code section 326.15 may be obtained from the vehicle and motor carrier services bureau at the address in subrule 400.6(1). The claim for refund shall be filed at the same address.

This rule is intended to implement Iowa Code sections 25.1, 321.126 to 321.128 and 326.15.
[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.51(321) Assigned identification numbers. The department is authorized to issue to the owner an assigned vehicle identification number for a vehicle, an assigned component part number for a component part, and an assigned product identification number for a fence-line feeder, grain cart, or tank wagon. An identification number shall be assigned only if the department is satisfied as to the true identity and ownership of the vehicle, component part, fence-line feeder, grain cart or tank wagon. When an assigned vehicle identification number has been issued for a vehicle, the vehicle shall be registered and titled under that number. An assigned component part number or an assigned product identification number shall be used only for identification purposes.

400.51(1) Issuance of an identification number. The department shall issue an assigned vehicle identification number, assigned component part number or assigned product identification number, as applicable, only if:

- a. The original number has been destroyed, removed or obliterated.
- b. The vehicle has had a cab, body, or frame change and the replacement cab, body, or frame is within the manufacturer's interchangeability parts specifications catalog and is compatible with the make, model, and year of the vehicle. If the replacement cab, body, or frame change is not within the manufacturer's interchangeability parts specifications catalog or is not compatible with the make, year, and model of the vehicle, the vehicle shall be considered reconstructed and subject to rule 761—400.16(321).
- c. The vehicle is a specially constructed, reconstructed, street rod or replica motor vehicle. See rule 761—400.16(321) for the requirements and procedures applicable to specially constructed, reconstructed, street rod or replica motor vehicles.

400.51(2) Procedures.

a. *Request.* Whenever an assigned identification number is required under subrule 400.51(1) and the request does not apply to a specially constructed, reconstructed, street rod or replica motor vehicle, the owner of the vehicle, component part, fence-line feeder, grain cart or tank wagon, or the person holding lawful custody, shall contact the department's bureau of investigation and identity protection at the address in subrule 400.6(2) and request the assignment of a number.

b. *Examination.* A motor vehicle investigator shall contact the owner and schedule a time and place for examination of the vehicle, component part, fence-line feeder, grain cart or tank wagon and ownership documents. The owner of the vehicle may drive or tow the vehicle to and from the examination location by completing the affidavit to drive section on the certification of compliance form. The affidavit shall state that the vehicle is reasonably safe for operation and must be signed by the owner.

If the vehicle has had a cab, body, or frame change, the owner shall have, for evidence of ownership for the replacement cab, body, or frame, a bill of sale with a description of the part, complete with the manufacturer's identification number, if any, and the name, address, and telephone number of the seller. The bill of sale, the vehicle, and the cab, body, or frame that has been replaced shall be made available for examination at the time and place scheduled.

c. *Assigned vehicle identification number.*

(1) The investigator upon approval of the request shall affix to the vehicle an assigned vehicle identification number and authorize the county treasurer to issue a title and registration for the vehicle.

(2) The owner shall submit the certificate of title and the registration receipt issued for the vehicle to the county treasurer. If the certificate of title is in the possession of a secured party, the county treasurer shall notify the secured party to return the certificate of title to the county treasurer for the purpose of issuing a corrected title. Upon receipt of the notification, the secured party shall submit the certificate of title within ten days. The county treasurer, upon receipt of the certificate of title and the registration receipt, shall issue a corrected title and registration receipt listing as the vehicle identification number the assigned vehicle identification number.

d. *Assigned component part number.* The investigator upon approval of the request shall affix to the component part an assigned component part number and give to the owner a component part form. The owner shall retain the form as a record of issuance and attachment. The form shall be made available on demand by any peace officer for examination.

e. Assigned product identification number. The investigator upon approval of the request shall affix an assigned product identification number to the fence-line feeder, grain cart or tank wagon and give to the owner an assigned product identification number form. The owner shall retain the form as a record of issuance and attachment. The form shall be made available on demand by any peace officer for examination.

400.51(3) Fees. A certificate of title fee and a fee for a notation of a security interest, if applicable, shall be collected by the county treasurer upon issuance of a corrected certificate of title. A corrected certificate of title shall not be required for a name change.

This rule is intended to implement Iowa Code sections 321.1, 321.43 and 321.92.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.52(321) Odometer statement.

400.52(1) Pursuant to Iowa Code section 321.71 and 49 U.S.C. Section 32705, an odometer disclosure statement shall be submitted with an application for certificate of title for a motor vehicle. The statement shall provide a current odometer reading and reflect whether the mileage is “actual,” “not actual” or “exceeds mechanical limits.”

400.52(2) If the transferor failed to provide an odometer disclosure statement or if the transferee lost the statement, and the transferee has attempted in good faith to contact the transferor to obtain a statement, the transferee may file a sworn statement of these facts on a form prescribed by the department. The sworn statement shall be accepted by the county treasurer or the department in lieu of the required odometer disclosure statement. The subsequent title issued from the sworn statement will record “not actual” mileage.

400.52(3) As required by 49 CFR Section 580.17, for vehicle transfers that occur through December 31, 2030, any vehicle that is model year 2011 or newer shall require an odometer disclosure statement. For vehicle transfers that occur on or after January 1, 2031, the model year formula for odometer disclosure statements shall be the current year minus 20. The resulting number represents the first model year for which a motor vehicle is exempt from the odometer statement requirements incident to a transfer.

This rule is intended to implement Iowa Code section 321.71.

[ARC 5829C, IAB 8/11/21, effective 9/15/21]

761—400.53(321) Stickers.

400.53(1) Placement of validation sticker. The validation sticker shall be affixed to the lower left corner of the rear registration plate. EXCEPTIONS: For motorcycle, autocycle and small trailer plates, the validation sticker shall be affixed to the upper left corner of the plate. For natural resources plates, the sticker may be affixed to the lower right corner of the rear plate.

400.53(2) Special fuel user identification sticker. If the vehicle uses a special fuel as defined in Iowa Code section 452A.2, a special fuel user identification sticker shall be issued. This sticker shall be displayed on the cover of the fuel inlet of the motor vehicle or on the outside panel of the motor vehicle within 3 inches of the fuel inlet so as to be in view when fuel is delivered into the motor vehicle.

400.53(3) Persons with disabilities parking sticker. A persons with disabilities special registration plate parking sticker shall be affixed to the lower right corner of the rear registration plate.

400.53(4) Special truck sticker. An owner of a special truck, registered pursuant to Iowa Code section 321.121, who has been issued either regular registration plates or special registration plates other than special truck registration plates must obtain from the county treasurer a sticker which distinguishes the vehicle as a special truck. The sticker shall be affixed to the lower right corner of the rear registration plate. EXCEPTION: If the vehicle displays front and rear plates, two stickers shall be issued with one sticker affixed to the lower right corner of the front plate and rear plate. For natural resources plates, the stickers must be affixed to the lower left corner of the front and rear plates.

This rule is intended to implement Iowa Code sections 321.34, 321.40, 321.41, 321.121 and 321.166.

[ARC 9833B, IAB 11/2/11, effective 12/7/11; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.54(321) Registration card issued for trailer-type vehicles. The registration card issued for trailer-type vehicles shall be carried in the vehicle which is described on the card or the registration card may be carried in the driver's compartment of the towing vehicle. If the registration card is carried in the vehicle which is described on such card, the registration card shall be enclosed in a registration card holder and the holder shall be attached to the vehicle so that the registration card may be viewed by any peace officer upon request.

This rule is intended to implement Iowa Code section 321.32.

761—400.55(321) Damage disclosure statement.

400.55(1) If the transferor failed to provide a damage disclosure statement or if the transferee lost the statement, and the transferee has attempted in good faith to contact the transferor to obtain a statement, the transferee may file a sworn statement of these facts. The transferee shall also complete section 2 of a separate damage disclosure statement and sign on the buyer's line. The sworn statement and damage disclosure statement completed by the transferee shall be accepted by the county treasurer or the department in lieu of the damage disclosure statement required from the transferor.

400.55(2) A model year formula for damage disclosure statements shall be the current year minus eight. The resulting number represents the first model year for which a motor vehicle is exempt from the damage disclosure statement requirements incident to a transfer.

400.55(3) If the transferor completes the damage disclosure on the assignment of title at the time of application for title, a transferor or transferee of a vehicle may submit a separate damage disclosure statement, Form 411108, indicating the damage level of the vehicle and whether the damage level exceeds 70 percent.

a. If the transferor signs both the damage disclosure on the assignment of title and the separate damage disclosure statement, Form 411108, the county treasurer shall accept the separate damage disclosure statement.

b. If the transferee signs the separate damage disclosure statement, Form 411108, the county treasurer shall accept the separate damage disclosure statement only if the separate damage disclosure statement indicates the damage level exceeds 70 percent. If the transferee's statement indicates the damage level is less than 70 percent, and there is no evidence that a prior Iowa title or foreign title was issued or designated as salvage, rebuilt or flood, the department shall review the transaction to confirm the damage level using data obtained from the insurance provider, motor vehicle repair facility, or other entity with direct knowledge of the damage.

This rule is intended to implement Iowa Code sections 321.52 and 321.69.

[ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—400.56(321) Hearings. The department shall send notice by certified mail to a person whose certificate of title, vehicle registration, license, or permit is to be revoked, suspended, canceled, or denied. The notice shall be mailed to the person's mailing address as shown on departmental records and shall become effective 20 days from the date mailed. A person who is aggrieved by a decision of the department and who is entitled to a hearing may contest the decision in accordance with 761—Chapter 13. The request shall be submitted in writing to the director of the vehicle and motor carrier services bureau at the address in subrule 400.6(1). The request for a contested case shall be deemed timely submitted if it is delivered or postmarked on or before the effective date specified in the notice of revocation, suspension, cancellation, or denial.

This rule is intended to implement Iowa Code sections 17A.10 to 17A.19, 321.101 and 321.102.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.57(321) Non-resident-owned vehicles. Rescinded IAB 2/6/02, effective 3/13/02.

761—400.58(321) Motorized bicycles. The following rules shall apply to motorized bicycles.

400.58(1) Maximum speed. If the department has reasonable cause to believe that a particular vehicle or model is capable of speeds exceeding 39 miles per hour, the department may conduct independent

tests to determine the maximum speed of the vehicle or model. If the department determines that the maximum speed of the particular vehicle or model exceeds 39 miles per hour, the vehicle or model shall not be registered as a motorized bicycle.

400.58(2) Identification of a vehicle as a motorized bicycle. Registration plates issued for motorcycles shall also be issued for motorized bicycles.

This rule is intended to implement Iowa Code sections 321.1 and 321.166.
[ARC 2887C, IAB 1/4/17, effective 2/8/17]

761—400.59(321) Registration documents lost or damaged in transit through the United States postal service. To obtain without cost the reissuance of registration documents that were sent by the county treasurer to the owner through the United States postal service and which were lost or damaged in transit, the owner of the vehicle shall file application for reissuance within 60 days of the date the documents were issued by the county treasurer.

This rule is intended to implement Iowa Code section 321.42.

761—400.60(321) Credit of registration fees.

400.60(1) Credit for unexpired registration fee. The applicant may claim credit, as specified in Iowa Code section 321.46(3), toward the registration fee for one newly acquired replacement vehicle. No credit shall be given for an unexpired electric vehicle annual registration fee; however, an unexpired electric vehicle annual registration fee is eligible for a refund as provided in rule 761—400.50(321,326).

a. The credit may be claimed only when the owner of the newly acquired vehicle is applying for a certificate of title and registration (or just registration if the vehicle is not subject to titling provisions) for the newly acquired vehicle.

b. For a junked vehicle, the date on the junking certificate shall determine the date the vehicle was junked.

c. Excess credit shall not be applied toward the registration fee for a second vehicle.

d. Credit shall be allowed for one or two vehicles which have been sold, traded or junked toward one replacement vehicle. Credit shall be based on the remaining unexpired months of the registration year(s) of the vehicle(s) sold, traded or junked.

400.60(2) Credit for transfer to spouse, parent or child. Credit shall be allowed toward a new registration for a vehicle being transferred to the applicant from the applicant's spouse, parent or child, or from a former spouse pursuant to a dissolution of marriage decree, if application for the certificate of title and registration (or just registration if the vehicle is not subject to titling provisions) is made within 30 days after the date of transfer. If the owner is deceased, credit may be transferred under rule 761—400.14(321) of this chapter.

400.60(3) Credit from/to apportioned registration.

a. Pursuant to Iowa Code section 321.46A, an owner may claim credit toward the registration fees due when changing a vehicle's registration from apportioned registration under Iowa Code chapter 326 to registration under Iowa Code chapter 321. The owner shall surrender proof of apportioned registration to the county treasurer. Credit shall be allowed for the unexpired complete calendar months remaining in the registration year from the date the application is filed with the county treasurer.

b. Pursuant to Iowa Code sections 321.126 and 321.127, the owner or lessee of a motor vehicle may claim credit for the apportioned registration fees due when changing the vehicle's registration from registration by the county treasurer to apportioned registration. Application for apportioned registration shall be submitted to the department's vehicle and motor carrier services bureau; see 761—Chapter 500.

400.60(4) Assignment of credit and registration plates from lessor to lessee. When a lessee purchases the leased vehicle and within 30 days requests the assignment of the vehicle's fee credit and registration plates, the lessor shall assign the registration fee credit and registration plates for the purchased vehicle to the lessee.

This rule is intended to implement Iowa Code sections 321.46, 321.46A, 321.48, 321.116, 321.117, 321.126 and 321.127.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20; ARC 5178C, IAB 9/9/20, effective 10/14/20]

761—400.61(321) Reassignment of registration plates.

400.61(1) Registration plates may be reassigned if one of the owners listed on the registration receipt before the transfer is also a listed owner following the transfer.

400.61(2) Registration plates may be reassigned when credit is allowed toward a new registration for a vehicle being transferred to the owner's spouse, parent, or child, or to a former spouse pursuant to a dissolution of marriage decree. If the owner is deceased, plates may be transferred under rule 761—400.14(321).

400.61(3) Registration plates shall not be reassigned between a natural person or persons and a corporation, association, copartnership, company, or firm.

400.61(4) Registration plates may be reassigned and credit allowed if two or more corporations, associations, partnerships, or firms merge into one corporation, association, partnership or firm.

400.61(5) Registration plates may be assigned and credit allowed if an owner listed on the certificate of title and registration transfers ownership of the vehicle to a trust created by that owner.

This rule is intended to implement Iowa Code sections 321.34 and 321.46.

761—400.62(321) Storage of registration plates, certificate of title forms and registration forms. Registration plates, certificate of title forms and registration forms which are consigned to county treasurers by the department shall be stored in a secure location. The location may be within the office of the county treasurer which is accessible only to authorized persons or in a storage area located outside the general office area assigned to the county treasurer. Any storage area located outside the general office area assigned to the county treasurer shall be of the construction that it is accessible only to authorized persons, as designated by the county treasurer or department.

This rule is intended to implement Iowa Code sections 321.5, 321.8, and 321.167.

761—400.63(321) Disposal of surrendered registration plates. The county treasurer shall either destroy plates that have been surrendered to the county treasurer or return the surrendered plates to Iowa state industries for recycling.

This rule is intended to implement Iowa Code sections 321.5 and 321.171.

761—400.64(321) County treasurer's report of motor vehicle collections and funds. The county treasurer shall file the report provided for in Iowa Code section 321.153 in a manner prescribed by the department.

This rule is intended to implement Iowa Code section 321.153.

761—400.65 to 400.69 Reserved.

761—400.70(321) Removal of registration and plates by peace officer under financial liability coverage law. This rule applies to instances when a peace officer issues a citation and removes the registration receipt and registration plates of a motor vehicle registered in this state when the driver of the motor vehicle is unable to provide proof of financial liability coverage. This rule applies regardless of whether the vehicle was also impounded.

400.70(1) The peace officer shall forward the registration receipt and evidence of the violation to the county treasurer of the county in which the motor vehicle is registered. Evidence of the violation is one of the following:

a. A copy of the citation. The citation must either reference Iowa Code subparagraph 321.20B(4)“a”(3) or 321.20B(4)“a”(4), as applicable, or reference Iowa Code section 321.20B and indicate whether or not the vehicle was impounded.

b. A written statement from the peace officer listing the plate number of the registration plate removed from the vehicle and the vehicle owner's name. The statement must either reference Iowa Code subparagraph 321.20B(4)“a”(3) or 321.20B(4)“a”(4), as applicable, or reference Iowa Code section 321.20B and indicate whether or not the vehicle was impounded. The statement must be signed by the peace officer or an employee of the law enforcement agency.

400.70(2) The peace officer may either destroy removed plates or deliver the removed plates to the county treasurer for destruction.

This rule is intended to implement Iowa Code section 321.20B.

761—400.71(321) Lemon law designation. Rescinded IAB 11/7/07, effective 12/12/07.

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[◇] Two or more ARCs

CHAPTER 405
SALVAGE

761—405.1(321) Applicability. This chapter supplements 761—Chapter 400. It applies to salvage motor vehicles and foreign motor vehicles brought into Iowa that are or were salvage, rebuilt or junked. This chapter applies only to motor vehicles subject to registration except that owners of vehicles with a gross vehicle weight rating of 30,000 pounds or more are not required to submit a salvage theft examination to convert a salvage title to a regular title.

[ARC 5345C, IAB 12/30/20, effective 2/3/21]

761—405.2(321,321H) Definitions.

“*Authorized vehicle recycler*” means a person licensed under Iowa Code chapter 321H.

“*Foreign jurisdiction*” means a jurisdiction other than Iowa.

“*Iowa salvage title*” means an Iowa salvage certificate of title.

“*Junking certificate*” means an Iowa junking certificate.

“*New motor vehicle dealer*” means a dealer licensed under Iowa Code chapter 322 to sell new motor vehicles.

“*Previous owner*” as used in Iowa Code section 321.24 means the last titled owner.

“*Regular foreign title*” means a certificate of title issued by a foreign jurisdiction that allows the vehicle to be driven or moved upon a highway.

“*Regular Iowa title*” means an Iowa certificate of title that is not a salvage title.

“*Salvage theft examination certificate*” means a certificate, including an electronic certificate in the form and manner prescribed by the department, issued by a peace officer who has been specially certified to conduct salvage theft examinations as provided in Iowa Code section 321.52.

[ARC 5345C, IAB 12/30/20, effective 2/3/21; ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—405.3(321) Salvage title.

405.3(1) *Face of title.* Except for vehicles with a gross vehicle weight rating of 30,000 pounds or more, the following shall be printed on the face of an Iowa salvage title: SALVAGE.

405.3(2) *Assignment.* An Iowa or a foreign salvage title may be assigned only as provided in Iowa Code subsection 321.52(4). Except as provided in subrule 405.3(3), the transferee to whom an Iowa or a foreign salvage title is assigned shall apply for a new Iowa salvage title within 30 days after the date of assignment unless, within this time period, application for a regular title is made or a junking certificate is obtained.

405.3(3) *Reassignment.* Reassignment of an Iowa or a foreign salvage title by a licensed new motor vehicle dealer or by an authorized vehicle recycler is allowed, and the dealer or recycler is not required to obtain a new Iowa salvage title upon assignment of an Iowa or a foreign salvage title to the dealer or recycler, provided a vacant reassignment space is available on the title. If all reassignment spaces on an Iowa or a foreign salvage title assigned to the dealer or recycler have been used, the dealer or recycler shall obtain a new Iowa salvage title in accordance with subrule 405.3(2). The following shall be printed on the dealer reassignment portion of Iowa salvage titles: ONLY NEW MOTOR VEHICLE DEALERS OR RECYCLERS MAY REASSIGN THIS TITLE.

405.3(4) *Registration fees.*

a. An Iowa salvage title may be obtained without payment of the current registration fees or any delinquent registration fees or registration penalties. If the registration fees are delinquent at the time of issuance of an Iowa salvage title, no additional penalty shall accrue after issuance.

b. Any registration fees or registration penalties due at the time of issuance of an Iowa salvage title, together with the current registration fees if not already paid, shall be paid upon issuance of a regular title. However, a dealer is not required to pay current registration fees to obtain a regular title for a vehicle held for resale or trade. See rule 761—400.27(321,322) for any exceptions.

c. Notwithstanding any provision of this chapter to the contrary, an Iowa salvage title obtained by an insurer pursuant to the provisions under Iowa Code section 321.52(4) shall be issued free and clear of all liens and claims of ownership, including any outstanding registration fees or registration penalties.

405.3(5) Plates. Registration plates shall not be assigned when an Iowa salvage title is issued.
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 5345C, IAB 12/30/20, effective 2/3/21]

761—405.4 and 405.5 Reserved.

761—405.6(321) Iowa salvage title required.

405.6(1) Wrecked or salvage vehicle. A vehicle rebuilder or a person engaged in the business of buying, selling, or exchanging vehicles of a type required to be registered in this state upon acquisition of a wrecked or salvage vehicle shall obtain an Iowa salvage title or a junking certificate for the vehicle except as provided in subrule 405.3(3).

a. A wrecked or salvage vehicle is a damaged motor vehicle that:

- (1) Has repair costs exceeding 70 percent of its fair market value before it became damaged, and
- (2) Had a fair market value of \$500 or more before it became damaged.

b. Fair market value is the average retail value found in the National Automobile Dealers Association (NADA) Official Used Car Guide. If there is no value available, the motor vehicle division shall determine the fair market value upon request. The address is: Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278.

405.6(2) Insurer. An insurer upon acquisition of a motor vehicle as a result of a settlement with the motor vehicle owner arising out of damage to or unrecovered theft of the motor vehicle shall obtain an Iowa salvage title for the motor vehicle.

405.6(3) Application. Application for an Iowa salvage title shall be made within 30 days after the date of assignment to the transferee.

[ARC 5345C, IAB 12/30/20, effective 2/3/21; ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—405.7(321) Converting salvage title to regular title.

405.7(1) General application procedure.

a. To obtain a regular title, the owner in whose name the salvage title is issued or assigned shall pay the appropriate fees and surrender the salvage title when applying for the regular title.

b. To obtain a regular title, the applicant shall have completed a salvage theft examination certificate for the vehicle as required by Iowa Code section 321.52. However, a salvage theft examination certificate is not required if the vehicle has a gross vehicle weight rating of 30,000 pounds or more. See rule 761—405.15(321) for salvage theft examination.

c. A regular title and registration receipt issued pursuant to this subrule shall bear the designation “REBUILT-IA.”

405.7(2) Insurer’s certification. An insurer who has title pursuant to Iowa Code section 321.52(4) may submit an insurer’s certification in lieu of a salvage theft examination certificate.

a. The insurer’s certification shall:

- (1) Include the name and address of the insurance company and the VIN, year and make of the salvage titled vehicle.
- (2) Include a statement by the insurer certifying that the retail cost of repairs for all damages to the vehicle is less than \$3000.
- (3) Be dated and signed by an authorized representative of the insurer.

b. The insurer’s certification is not transferable if the insurer assigns the salvage title to another person.

c. A regular title and registration receipt issued pursuant to this subrule is not required to have a designation of “REBUILT-IA.” However, the title and registration receipt shall bear any designation to be carried forward, as explained in rule 761—405.10(321).

[ARC 5345C, IAB 12/30/20, effective 2/3/21]

761—405.8(321) Foreign vehicles.

405.8(1) Definitions. The following definitions apply to foreign titles and the designations shown on them.

“*Junked*” means the vehicle is damaged or dismantled and is prohibited from ever again being driven upon a highway.

“*Rebuilt*” means the vehicle had been designated as salvage but had the designation removed, and the vehicle is permitted to be driven and moved upon a highway. Also, a designation of “salvage” on a regular foreign title means that the vehicle is rebuilt.

“*Salvage*” means the vehicle is damaged and shall not be registered to be driven or moved upon a highway until it is no longer designated as salvage.

405.8(2) *Foreign title with rebuilt designation.* If the prior title for a vehicle is a foreign title indicating that the vehicle was rebuilt, the Iowa title and registration receipt issued from the foreign title shall contain the designation of “rebuilt” together with the two-letter abbreviation of the name of the jurisdiction that issued the foreign title.

EXCEPTION: If a records check indicates that the vehicle was previously titled in Iowa with a designation of “prior salvage,” the prior salvage designation shall be redesignated as “REBUILT-IA” and the “REBUILT-IA” designation takes precedence and shall be carried forward to the Iowa title and registration receipt. If a records check indicates that the vehicle was previously titled in Iowa with a designation of “REBUILT-IA,” the “REBUILT-IA” designation takes precedence and shall be carried forward to the Iowa title and registration receipt.

405.8(3) *Converting foreign salvage title to Iowa title.* If the prior title for a vehicle is a foreign title indicating that the vehicle is salvage, a regular Iowa title shall not be issued for the vehicle unless an Iowa salvage title is first issued. After an Iowa salvage title is issued for the vehicle, a regular Iowa title may be obtained pursuant to rule 761—405.7(321).

EXCEPTION 1: As provided in 405.3(3), a licensed new motor vehicle dealer or an authorized vehicle recycler is not required to obtain an Iowa salvage title upon assignment of a foreign salvage title to the dealer or recycler, provided a vacant reassignment space is available on the title.

EXCEPTION 2: As provided in Iowa Code section 321.24(5), an owner who surrenders a foreign salvage title and obtains a salvage theft examination pursuant to Iowa Code section 321.52(4) “b” within 30 days of the date the owner was assigned the foreign salvage title is not required to first obtain an Iowa salvage title.

405.8(4) *Salvage titled vehicle leaving and reentering Iowa.* If a vehicle leaves Iowa with an Iowa salvage title and reenters Iowa with a regular foreign title, a regular Iowa title may be issued without a salvage theft examination. The regular Iowa title and registration receipt issued from the foreign title will be designated:

- a. “REBUILT-IA” if the foreign title does not indicate that the vehicle was rebuilt.
- b. As specified in subrule 405.8(2) if the foreign title indicates that the vehicle was rebuilt.

405.8(5) *Designation carried forward.* If a vehicle leaves Iowa with a regular Iowa title and reenters Iowa with a regular foreign title and if the foreign title does not indicate that the vehicle was rebuilt and if a records check indicates that the vehicle had a designation listed in paragraphs 405.10(1) “a” through “f,” that designation shall be carried forward to the Iowa title and registration receipt issued from the foreign title.

405.8(6) *Foreign title with flood, fire, vandalism or theft designation.* If the prior title for a vehicle is a foreign title indicating that the vehicle was damaged by flood, fire or vandalism or is a recovered stolen vehicle and another designation is not required under this rule or rule 761—405.10(321), the Iowa title and registration receipt issued from the foreign title shall contain, as applicable, the designation of “flood,” “fire,” “vandalism” or “theft.”

405.8(7) *Foreign title with a lemon buy-back designation.* See rule 761—405.10(321).

405.8(8) *Junking certificate.*

- a. An Iowa junking certificate shall be issued if:
 - (1) The prior title for a vehicle is a foreign title indicating that the vehicle was junked, regardless of any other designation on the title.
 - (2) A records check for a vehicle with a foreign title indicates that the vehicle had previously been issued an Iowa junking certificate.

b. This subrule applies to all vehicles subject to Iowa titling laws.
[ARC 3108C, IAB 6/7/17, effective 7/12/17; ARC 5345C, IAB 12/30/20, effective 2/3/21; ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—405.9(321) Records check. Before a title is issued in Iowa, a computer records check may be made. The purpose of the records check is to:

405.9(1) Determine if the vehicle ever had or should have had a “prior salvage,” “rebuilt,” “damage over 50 percent,” “damage over 70 percent,” “flood,” “fire,” “vandalism,” “theft,” “lemon buy-back,” or equivalent designation(s) on a previous title. If such a designation is or should have been on a previous title, the Iowa title to be issued shall contain the designation required by this chapter.

405.9(2) Determine if the vehicle is or was ever a wrecked or salvage vehicle as defined in Iowa Code section 321.52. If a vehicle is a wrecked or salvage vehicle, an Iowa salvage title shall be issued. If the vehicle was a wrecked or salvage vehicle, the Iowa title to be issued shall contain the appropriate designation required by this chapter.

405.9(3) Determine if the vehicle should have been or was ever junked as defined in subrule 405.8(1). If the vehicle should have been or was ever junked, an Iowa junking certificate shall be issued.
[ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—405.10(321,322G) Designations.

405.10(1) The following designations for a vehicle shall be used on Iowa titles and registrations receipts and shall be carried forward to all subsequent Iowa titles and registration receipts issued for the vehicle, unless otherwise specified:

a. “REBUILT-IA.” This designation supersedes other designations. When a designation of “REBUILT-IA” is required pursuant to rule 761—405.7(321), it replaces any other designation.

b. Rebuilt together with a two-letter abbreviation of the name of a foreign jurisdiction. When this designation is required pursuant to subrule 405.8(2), it replaces any other designation except a “REBUILT-IA” designation.

c. Damage over 50 percent. The designation shall be used for applicable vehicle transfers occurring prior to July 1, 2021, and shall be carried forward for applicable vehicle transfers occurring prior to July 1, 2021.

d. Damage over 70 percent. As required by Iowa Code section 321.69, a designation of “damage over 70 percent” shall be used when the seller or the buyer indicates on the damage disclosure statement that the person has knowledge that the motor vehicle sustained damage for which the cost of the repair exceeded 70 percent of the fair market value before the motor vehicle became damaged. This designation replaces any other designation except “rebuilt.”

e. Flood, fire, vandalism or theft. The most recent designation applies. Unless superseded by a “REBUILT-IA,” “rebuilt,” “damage over 50 percent” or “damage over 70 percent” designation, a designation of “flood,” “fire,” “vandalism” or “theft” shall be used as specified in subrule 405.8(6) and supersedes a “lemon buy-back” designation.

f. Lemon buy-back. Unless superseded by a “REBUILT-IA,” “rebuilt,” “damage over 50 percent,” “damage over 70 percent,” “flood,” “fire,” “vandalism” or “theft” designation, a designation of “lemon buy-back” shall be used:

(1) When a certificate of title is issued to a manufacturer of a motor vehicle pursuant to Iowa Code section 322G.12.

(2) When the prior certificate of title for a motor vehicle is a foreign title indicating that the vehicle was returned to the manufacturer pursuant to Iowa Code chapter 322G or a law of another state similar to Iowa Code chapter 322G.

405.10(2) An Iowa salvage title will be issued with a designation of “salvage” unless a designation listed in subrule 405.10(1) is required.

[ARC 5345C, IAB 12/30/20, effective 2/3/21; ARC 6220C, IAB 3/9/22, effective 4/13/22]

761—405.11 to 405.14 Reserved.

761—405.15(321) Salvage theft examination. Except for foreign salvage titles assigned to licensed new motor vehicle dealers, authorized vehicle recyclers, or educational institutions, a salvage theft examination may only be conducted on a vehicle with an Iowa salvage title. The vehicle shall not be examined until it has been completely repaired, except for minor body parts such as trim, body marking or paint.

405.15(1) General procedure.

a. A salvage theft examination shall be conducted by a peace officer who has been specially certified, and recertified when required, by the Iowa law enforcement academy to perform salvage theft examinations.

(1) To arrange for a salvage theft examination by an investigator from the department, the applicant shall contact the Bureau of Investigation and Identity Protection, Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3050; or on the department's website at www.iowadot.gov.

(2) To arrange for a salvage theft examination by any other authorized peace officer, the applicant shall contact the local law enforcement agency for instructions.

b. The owner of the vehicle may drive the vehicle to and from the examination location by completing the permit to drive located within the electronic affidavit of salvage vehicle repairs form.

(1) The affidavit shall state that the vehicle is reasonably safe for operation and shall list the parts that have been replaced on the vehicle. The affidavit must be signed by the owner or the owner's authorized agent.

(2) To be valid, the permit to drive the vehicle to and from the examination location must be signed by the owner or owner's authorized agent.

c. The owner of the vehicle or the owner's representative must be present for the examination.

d. The owner or owner's representative, when appearing with the vehicle for the examination, shall submit to the peace officer for review the salvage title or a certified copy of the salvage title; the affidavit of salvage vehicle repairs; and, pursuant to subrules 405.15(3) and 405.15(4), bills of sale for all component parts replaced.

e. The owner or owner's representative shall electronically make payment for the salvage theft examination at the time the examination is scheduled, and the fee collected shall be distributed in accordance with Iowa Code section 321.52(4) "c." The owner shall have three years from the date the affidavit and payment were submitted to complete the salvage theft examination without having to pay a new fee.

f. If the vehicle passes the salvage theft examination, the peace officer shall approve the completed salvage theft examination certificate.

g. Reserved.

h. The peace officer shall return the salvage title or the certified copy of the salvage title, the permit to drive section, if applicable, on the affidavit of salvage vehicle repairs, and the bills of sale to the owner or the owner's representative.

405.15(2) Affidavit of salvage vehicle repairs form and salvage theft examination certificate.

a. The affidavit of salvage vehicle repairs form shall be accessed on the department's website.

b. If a peace officer finds it necessary to use a physical salvage theft examination certificate, the salvage theft examination certificate shall be a controlled form and furnished by the department.

c. The owner of the vehicle may obtain a duplicate copy of the salvage theft examination certificate upon written request to the department.

d. The approved salvage theft examination certificate is not transferable to a different party or owner.

405.15(3) Bill of sale. A bill of sale is a document from the seller to the buyer containing the name, address and telephone number of the seller, a description and identification number of the component part and, if applicable, the vehicle identification number (VIN) of the vehicle from which it was removed.

405.15(4) Component part. For salvage theft examinations, the definition of component part as found in Iowa Code section 321.1 shall apply.

[ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3108C, IAB 6/7/17, effective 7/12/17; ARC 5345C, IAB 12/30/20, effective 2/3/21]

These rules are intended to implement Iowa Code sections 321.24, 321.52, 321.69 and 322G.12.

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[Filed ARC 3999C (Notice ARC 3890C, IAB 7/18/18), IAB 9/12/18, effective 10/17/18]

[Filed ARC 5345C (Notice ARC 5233C, IAB 10/21/20), IAB 12/30/20, effective 2/3/21]

[Filed ARC 6220C (Notice ARC 6066C, IAB 12/1/21), IAB 3/9/22, effective 4/13/22]

CHAPTER 411
PERSONS WITH DISABILITIES PARKING PERMITS

[Prior to 6/3/87, Transportation Department [820]—(07,D) Ch 1]

761—411.1(321L) Information and applications. Information and applications regarding persons with disabilities parking permits are available, electronically or otherwise, by mail from the Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3110; by facsimile at (515)237-3056; by email at vsusto@iowadot.us; or on the department's website at www.iowadot.gov. [ARC 3450C, IAB 11/8/17, effective 12/13/17; ARC 6218C, IAB 3/9/22, effective 4/13/22]

761—411.2(321L) Definitions.

411.2(1) The definitions in Iowa Code section 321L.1 are hereby made part of and fully incorporated in this chapter.

411.2(2) As used in this chapter:

“*Child*” means the same as defined in 761—subrule 401.20(2).

“*Health care provider*” means a physician licensed under Iowa Code chapter 148 or 149, a physician assistant licensed under Iowa Code chapter 148C, an advanced registered nurse practitioner licensed under Iowa Code chapter 152, a chiropractor licensed under Iowa Code chapter 151, or a physician, physician assistant, nurse practitioner, or chiropractor licensed to practice in a contiguous state as set forth in Iowa Code section 321L.2(1).

“*Nonexpiring removable windshield placard*” means a removable windshield placard issued on or before December 31, 2016, to a person with a permanent disability.

“*Organization*” means an applicant that is a corporation, partnership, sole proprietorship, business trust, estate, trust, limited liability company, association, joint venture, government, governmental subdivision, agency, instrumentality, public corporation, or any other legal or commercial entity lawfully doing business in the state of Iowa that has a program for transporting persons with disabilities or elderly persons.

“*Permanent disability*” means an applicant is a person with a disability as defined in Iowa Code section 321L.1(8) and the disability will continue indefinitely without resolution and is reasonably expected to last the applicant's lifetime.

“*Standard removable windshield placard*” means a removable windshield placard issued on or after January 1, 2017, to a person with a permanent disability.

“*Statement of disability*” means a communication, electronic or otherwise, originating from the applicant's health care provider, which attests that the applicant is a person with a disability as defined in Iowa Code section 321L.1(8). The statement must state the nature of the applicant's disability and indicate whether the applicant's disability is “temporary” or “permanent.” If the disability is temporary, the statement shall state the period of time during which the applicant is expected to be disabled and the period of time for which the permit should be issued, not to exceed six months. The statement must be written on the health care provider's stationery.

“*Stationery*” means any communication, electronic or otherwise, from which the department may reasonably identify, on or within its contents, that it originated from the applicant's health care provider.

“*Temporary disability*” means an applicant is a person with a disability as defined in Iowa Code section 321L.1(8) and the disability is not permanent and is reasonably expected to last for only a limited period of time.

“*Temporary removable windshield placard*” means a removable windshield placard issued to a person with a temporary disability.

[ARC 3450C, IAB 11/8/17, effective 12/13/17; ARC 6218C, IAB 3/9/22, effective 4/13/22]

761—411.3(321L) Application for persons with disabilities parking permit.

411.3(1) General. An applicant shall submit a completed application for a persons with disabilities parking permit, including required supporting documentation, pursuant to this chapter and Iowa Code section 321L.2.

a. An applicant may request one of the following persons with disabilities parking permits by completing Form 411055:

- (1) Temporary removable windshield placard.
- (2) Standard removable windshield placard.
- (3) Persons with disabilities special registration plate parking sticker.
- (4) Persons with disabilities special registration plates. An applicant seeking persons with disabilities special registration plates must also submit an application as described in rule 761—401.20(321).

b. An organization seeking a persons with disabilities removable windshield placard shall complete Form 411355. An application made by an organization does not have to include a statement of disability.

411.3(2) Application requirements. An application shall include the applicant's full legal name, address, date of birth, social security number or Iowa driver's license number or Iowa nonoperator's identification number, and a statement of disability from the applicant's health care provider. However, if the application is made on behalf of a person who is less than one year old, pursuant to Iowa Code section 321L.2, the department may accept the application without the requirement to include a social security number, Iowa driver's license number, or nonoperator's identification card number for the person. In lieu of a statement of disability from a health care provider, an applicant who is certified by the U.S. Department of Veterans Affairs as having a permanent disability may submit both of the following with an otherwise completed persons with disabilities parking permit application:

a. Proof that the applicant is the subject of a certification of disability from the U.S. Department of Veterans Affairs.

b. A self-certification, verified under penalty of perjury, that states the nature of the applicant's disability and attests that the disability certified by the U.S. Department of Veterans Affairs is a permanent disability that impairs the applicant's mobility to the extent defined in Iowa Code section 321L.1(8). The self-certification must be attested to on the persons with disabilities parking permit application.

411.3(3) Availability of application. Applications may be obtained from any of the following:

- a. The department's website as set forth in rule 761—411.1(321L).
- b. The department's motor vehicle division.
- c. A driver's license service center.
- d. A county treasurer's office.

411.3(4) Application submission. Completed applications shall be submitted in any of the following ways:

a. By mail to the Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by facsimile at (515)237-3056; or by email at ycusto@iowadot.us.

- b. In person at a driver's license service center.
- c. To the county treasurer's office.

411.3(5) Application submitted by an organization. An application submitted by an organization shall include the name of the organization; the name of its authorized representative; the mailing address, telephone number, and signature of its authorized representative; and if required to obtain one, the organization's federal employer identification number or federal tax identification number.

[ARC 3450C, IAB 11/8/17, effective 12/13/17; ARC 6218C, IAB 3/9/22, effective 4/13/22]

761—411.4(321L) Removable windshield placards.

411.4(1) Nonexpiring removable windshield placards.

a. *Period of validity.* A nonexpiring removable windshield placard issued on or before December 31, 2016, shall remain valid until the occurrence of any condition set forth in Iowa Code section 321L.3(1), the procedure set forth in rule 761—411.8(321L), and as otherwise specified by statute or rule.

b. Replacement. A lost, stolen, or damaged nonexpiring removable windshield placard shall be replaced with a standard removable windshield placard.

411.4(2) Standard removable windshield placards. A standard removable windshield placard may be issued only to a person with a permanent disability. A standard removable windshield placard shall not be issued to a person with a temporary disability or to an organization.

a. Period of validity. A standard removable windshield placard shall be valid for five years, and shall expire on the last day of the last month, five years from the month from which it was issued.

b. Renewal.

(1) Submission of application. A person who holds a valid standard removable windshield placard may renew the placard by submitting a persons with disabilities parking permit application pursuant to rule 761—411.3(321L) that includes all required documentation and shows the applicant remains permanently disabled and has a continuing need for the placard.

(2) Timing of renewal application. An application to renew a standard removable windshield placard may be submitted up to 30 days before the current placard's expiration. The renewal or replacement placard shall be valid for five years, and shall expire on the last day of the last month, five years from the month from which it was issued.

411.4(3) Temporary removable windshield placards. A temporary removable windshield placard may be issued to the applicant if the application demonstrates the applicant has a temporary disability. A temporary removable windshield placard shall not be issued to an organization.

a. Period of validity. A temporary removable windshield placard shall be valid for the period of time during which the applicant is expected to be disabled and the period of time for which the permit should be issued as shown by the statement of disability, but not to exceed six months.

b. Renewal.

(1) Submission of application. A person who holds a valid temporary removable windshield placard may renew the placard by submitting a persons with disabilities parking permit application pursuant to rule 761—411.3(321L) that includes all required documentation and shows the applicant remains temporarily disabled.

(2) Timing of renewal application. An application to renew a temporary removable windshield placard may be submitted up to 30 days before the current placard's expiration. The renewal placard shall be valid for the period of time during which the applicant is expected to be disabled and the period of time for which the permit should be issued as shown by the statement of disability, but not to exceed six months.

411.4(4) Removable windshield placards for an organization. An organization may be issued a removable windshield placard. A removable windshield placard issued to an organization shall be valid for four years and shall expire on the last day of the last month, four years from the month from which it was issued. The placard shall bear the name of the organization and the signature of its authorized representative. The organization may renew a placard issued to it by submitting a persons with disabilities parking permit application pursuant to rule 761—411.3(321L) provided the organization continues to provide the service for which the placard was issued. If at any time the organization ceases providing the service for which the placard was issued, the organization shall immediately surrender the placard to the department.

411.4(5) Display of placards. A removable windshield placard shall only be displayed when the vehicle is parked in a persons with disabilities parking space. The removable windshield placard shall be displayed in a manner that allows the entire placard to be visible through the vehicle's windshield.

[ARC 3450C, IAB 11/8/17, effective 12/13/17]

761—411.5(321L) Persons with disabilities special registration plate parking stickers.

411.5(1) Eligibility. A persons with disabilities special registration plate parking sticker may be issued to a person with a permanent disability who owns a motor vehicle for which the person has been issued disabled veteran plates under Iowa Code section 321.105 or registration plates under Iowa Code section 321.34. A special registration plate parking sticker shall not be issued to a person with a

temporary disability or to an organization. In no event shall a special registration plate parking sticker be placed on persons with disabilities special plates issued under Iowa Code section 321.34(14).

411.5(2) *Validity.* The special registration plate parking sticker shall remain valid for such period of time that the registration for the vehicle remains valid.

411.5(3) *Display.* The special registration plate parking sticker shall be affixed to the lower right corner of the rear registration plate, as required by rule 761—400.53(321).

[ARC 3450C, IAB 11/8/17, effective 12/13/17; ARC 6218C, IAB 3/9/22, effective 4/13/22]

761—411.6(321L) Persons with disabilities special registration plates. See 761—Chapter 401.

[ARC 3450C, IAB 11/8/17, effective 12/13/17]

761—411.7(321L) Return of persons with disabilities parking permit. A persons with disabilities parking permit issued pursuant to this chapter and Iowa Code section 321L.2 shall be returned to the department, to a driver’s license service center, or to any law enforcement office within ten days of an occurrence of any of the events set forth in Iowa Code section 321L.3(1) and in the manner prescribed in Iowa Code section 321L.3(3).

[ARC 3450C, IAB 11/8/17, effective 12/13/17; ARC 6218C, IAB 3/9/22, effective 4/13/22]

761—411.8(321L) Revocation of a persons with disabilities parking permit.

411.8(1) *Notice of revocation.* Notice of revocation shall be in writing and shall specify the basis of the department’s determination.

411.8(2) *Effective date of permit revocation.* Unless otherwise specified by statute or rule, a permit shall be considered revoked 30 days after the department’s notice of revocation is served.

411.8(3) *Service of notice.* The department shall send a notice of revocation by first-class mail to the mailing address as shown on the pertinent application for a persons with disabilities parking permit.

411.8(4) *Departmental verification of service of notice.* The department may prepare an affidavit of mailing verifying the fact that a notice was mailed by first-class mail. To verify the mailing of a notice, the department may use its records in conjunction with U.S. Postal Service records available to the department. The department’s affidavit of mailing may be attested to and certified in accordance with Iowa Code section 622.1.

[ARC 3450C, IAB 11/8/17, effective 12/13/17]

761—411.9(321L) Appeal.

411.9(1) A person or organization whose persons with disabilities parking permit has been revoked may request an informal settlement or a contested case proceeding as provided in 761—Chapter 13 to contest said action.

411.9(2) The request shall be submitted in writing, to the director of the motor vehicle division, at the address listed in rule 761—411.1(321L), and may be submitted by email or other means prescribed by the department. To be timely, the request must be submitted within ten days of the receipt of notice of revocation.

411.9(3) When the department receives a properly submitted, timely request for an informal settlement or contested case proceeding or an appeal of a presiding officer’s proposed decision regarding a revocation, the department shall stay the revocation pending resolution of the informal resolution, contested case, or appeal.

[ARC 3450C, IAB 11/8/17, effective 12/13/17; ARC 6218C, IAB 3/9/22, effective 4/13/22]

These rules are intended to implement Iowa Code sections 321L.1 to 321L.4 and 321L.8.

[Filed 11/22/76, Notice 10/6/76—published 12/15/76, effective 1/19/77]

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[Filed ARC 6218C (Notice ARC 6075C, IAB 12/15/21), IAB 3/9/22, effective 4/13/22]

CHAPTER 450
MOTOR VEHICLE EQUIPMENT

[Appeared as Ch 1, Department of Public Safety, 1973 IDR; amended January 1975 IDR Supplement]
[Prior to 6/3/87, Transportation Department[820]—(07,E)Ch 1]

761—450.1(321) Addresses, information and forms. Assistance under this chapter is available as follows:

450.1(1) Information and forms for vehicle registration and certificate of title may be obtained from the county treasurer or by mail from the Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3264; or on the department's website at www.iowadot.gov.

450.1(2) Information for inspections may be obtained from the Bureau of Investigation and Identity Protection, Iowa Department of Transportation, 6310 SE Convenience Boulevard, Ankeny, Iowa; by telephone at (515)237-3050; or on the department's website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3.
[ARC 5203C, IAB 10/7/20, effective 11/11/20; ARC 6219C, IAB 3/9/22, effective 4/13/22]

761—450.2(321) Equipment requirements for specially constructed, reconstructed, street rod, and replica motor vehicles, other than autocycles, motorcycles and motorized bicycles. The following standards are minimum requirements for constructing and equipping specially constructed, reconstructed, street rod, and replica motor vehicles other than autocycles, motorcycles and motorized bicycles.

450.2(1) Definitions. The definitions in Iowa Code section 321.1 and rule 761—400.16(321) are hereby made part of this chapter.

450.2(2) Application. As outlined in rule 761—400.16(321), the applicant shall submit the required application forms and exhibits to the county treasurer. The vehicle and ownership documents shall be examined by the department. If the department determines that the motor vehicle complies with this rule, that the integral parts and components have been identified as to ownership, and that the application forms have been completed properly, the department shall assign an identification number to the vehicle and certify that the motor vehicle is eligible for titling and registration. If the frame or unibody specified on an application for a specially constructed, reconstructed, street rod, or replica motor vehicle is designated "not for highway use," the application shall not be approved. The exchange of compatible body parts does not constitute a specially constructed, reconstructed, street rod, or replica motor vehicle. The removal, addition, or substitution of reconstructed motor vehicle parts that modifies the vehicle's external appearance so that it does not reflect the original make or manufacturer model for that model does constitute a specially constructed, reconstructed, street rod, or replica motor vehicle.

450.2(3) Defroster and defogging device. Every closed motor vehicle shall be equipped with a device capable of defogging or defrosting the windshield area.

450.2(4) Door latches. Every motor vehicle that is equipped with doors leading directly into a compartment that contains one or more seating accommodations shall be equipped with mechanically actuated door latches which firmly and automatically secure the door when pushed closed and which allow each door to be opened from the inside by the actuation of a convenient lever, handle or other nonelectric device. Interior handles must be visible.

450.2(5) Floor pan. Every motor vehicle shall be equipped with a floor pan under the entire passenger-carrying compartment. The floor pan shall support the weight of the number of occupants that the vehicle is designed to carry. The floor pan shall be so constructed that it prevents the entry of exhaust fumes.

450.2(6) Glazing.

a. Windshields. Every motor vehicle shall be equipped with a laminated safety glass windshield that complies with and bears the approval marking of the American National Standards Institute (ANSI) Z 26.1 Standard. The windshield shall be in such a position that it affords continuous horizontal frontal protection to the driver and front seat occupants. The minimum vertical height of the unobstructed

windshield glass shall be 6 inches. This paragraph does not preclude the use of a windshield that can be folded down to a horizontal position, provided that the windshield can be firmly fastened in both the vertical and horizontal positions.

b. Side and rear glass. Side and rear glass is not required in motor vehicles. If present, however, this glass must be either laminated or tempered safety glass bearing the approval of the ANSI Z 26.1 Standard.

450.2(7) Driver visibility. Each motor vehicle shall provide the driver with a minimum outward horizontal vision capability of 90 degrees each side of a vertical plane passing through the fore and aft centerline of the vehicle. This plane of vision may be interrupted by window framing and windshield door support posts not exceeding 4 inches in width at each side location.

450.2(8) Hood latches. If a motor vehicle is equipped with a front-opening hood, that hood shall be equipped with a primary and secondary latching system to hold the hood in a closed position.

450.2(9) Instruments and controls. Each motor vehicle shall be equipped with:

a. An operating speedometer calibrated to indicate “miles per hour.”
b. An operating odometer calibrated to indicate “total miles driven.”
c. A steering wheel circular or nearly circular in shape, having an outside diameter of not less than 13 inches.

d. An accelerator control system that returns the engine throttle to an idle position automatically when the driver removes the actuating force from the accelerator control.

450.2(10) Brakes.

a. Every motor vehicle shall be equipped with brakes acting upon all wheels. The service brakes must be capable of meeting or exceeding the stopping requirements of Iowa Code section 321.431. If necessary, the braking system may be tested by a road test on a public roadway by an officer of the motor vehicle division of the department.

b. Every motor vehicle shall be equipped with a parking brake operating on at least two wheels applied with required effectiveness despite exhaustion of any source of energy or leakage of any kind in the service brake system. The parking brake shall meet the requirements of Iowa Code sections 321.430 and 321.431.

450.2(11) Rearview mirror. Every motor vehicle shall be equipped with two rearview mirrors, each having substantial unit magnification. One shall be mounted on the inside of the vehicle in such a position that it affords the driver a clear view to the rear. The other shall be mounted on the outside of the vehicle on the driver’s side in such a position that it affords the driver a clear view to the rear. When an inside mirror does not give a clear view to the rear, a right-hand outside mirror shall be required in lieu thereof. The mirror mounting shall provide a stable support for the mirror, and shall provide for mirror adjustment by tilting in both horizontal and vertical directions. Each mirror shall have a minimum of 10 square inches of reflective surface.

450.2(12) Seat belts. Every motor vehicle shall be equipped with at least a Type I (lap belt) seat belt for the driver and each passenger seating position. The belts at each location shall comply with DOT Motor Vehicle Safety Standard No. 209, and shall be firmly anchored to the vehicle body.

450.2(13) Seating. All bench-type and individual seats in motor vehicles shall be firmly anchored to structural components or body parts.

450.2(14) Fenders and mud flaps. Rescinded IAB 9/8/10, effective 10/13/10.

450.2(15) Bumpers. Rescinded IAB 9/8/10, effective 10/13/10.

450.2(16) Exhaust system. Every motor vehicle shall have an exhaust system meeting the following requirements:

a. The system shall be free of leaks, including the exhaust manifold (or headers), piping forward of the muffler, the muffler(s), and tail piping.

b. Exhaust fumes shall be emitted to the extremity of the vehicle, behind the rear wheels, or to the extremity of the vehicle within 6 inches in front of the rear wheels. Exhaust fumes from trucks, other than enclosed vans, may be emitted to the rear of that part of the vehicle designed for and normally used for carrying the driver and passengers.

c. Each exhaust system must be equipped with a muffler that prevents excessive noise.

d. No part of the exhaust system shall pass through any area of the vehicle that is used as a passenger-carrying compartment, and shall be so constructed that persons entering the vehicle cannot make contact with the exhaust system.

e. All exterior side exhaust pipes must be fully shielded and any vertical truck exhaust stacks shall be shielded to the top of the cab.

450.2(17) Frame. Every vehicle shall be equipped with a frame consisting of wall box tubing, round tubing, wall channel or unitized construction capable of supporting the vehicle, its load and the torque produced by the power source.

450.2(18) Fuel system. Every motor vehicle shall have a fuel system in which all components are securely fastened with fasteners designed for this purpose, including the tank, tubing, hoses, clamps, etc. The filler from the system shall be located in a position not within the passenger-carrying compartment, and shall be capped. The system shall be leakproof, and fuel lines shall be positioned so as not to come in contact with high temperature surfaces or moving parts.

450.2(19) Steering and suspension.

a. Every motor vehicle shall have no parts extending below the wheel rims in their lowest position, except for tires and electrical grounding devices designed for this purpose.

b. The steering system shall remain unobstructed when turned from lock to lock.

c. The steering wheel shall have no less than two turns and no more than six turns when turning the road wheels from lock to lock.

d. While in a sharp turn at a speed between 5 and 15 MPH, release of the steering wheel shall result in a distinct tendency for the vehicle to increase its turning radius.

e. No motor vehicle shall be constructed so that the weight on any axle is less than 20 percent of the gross weight of the vehicle and load.

f. Motor vehicles shall be equipped with a damping device at each wheel location providing a minimum relative motion between the unsprung axle and the chassis of plus or minus 2 inches.

g. When each corner of the vehicle is depressed and released the damping device shall stop vertical body motion within two cycles.

h. There shall be no heating or welding on coil springs, leaf springs, or torsion bars.

450.2(20) Tires. Tires shall comply with Iowa Code section 321.440. Each tire shall have a load-bearing capacity in keeping with the size and weight of the vehicle.

450.2(21) Lighting and electrical system. Each motor vehicle shall be equipped with approved lighting devices in sufficient number, type, and locations to meet the requirements of Iowa Code sections 321.384 to 321.423, including headlamps, rear lamps, license plate lamp, rear reflectors, parking lamps, stop lamps, turn signals, and high-low beam indicator. In addition, every motor vehicle shall be equipped with:

a. A driver-controlled switch capable of selecting high and low beams (dimmer switch).

b. A motor vehicle more than 40 inches in width shall be equipped with turn signal lamps and have a manually operated switch controlled by the driver that shall cause the turn signal lamps to function. This switch shall be self-canceling.

c. A horn that shall be electrically actuated, and shall emit a sound clearly audible from a distance of 200 feet. The horn shall be actuated with a switch easily accessible to the driver when operating the vehicle.

d. All wiring shall be done in an orderly and workmanlike fashion, with no wiring in contact with high temperature surfaces or moving parts.

e. Headlamps shall be in a plane that is perpendicular to a vertical plane through the longitudinal centerline of the vehicle. The headlamps shall be mounted not less than 24 inches, nor more than 54 inches, above the road surface when measured to the headlamp center.

f. A tail lamp or lamps shall be mounted on the rear of the motor vehicle or vehicle, exhibiting a red light plainly visible from a distance of 500 feet to the rear. The tail lamp or lamps shall be mounted not less than 15 inches, nor more than 72 inches, above the roadway.

g. All original lamps and lighting equipment provided on the motor vehicle by the manufacturer shall be maintained in working condition or shall be replaced with equivalent equipment.

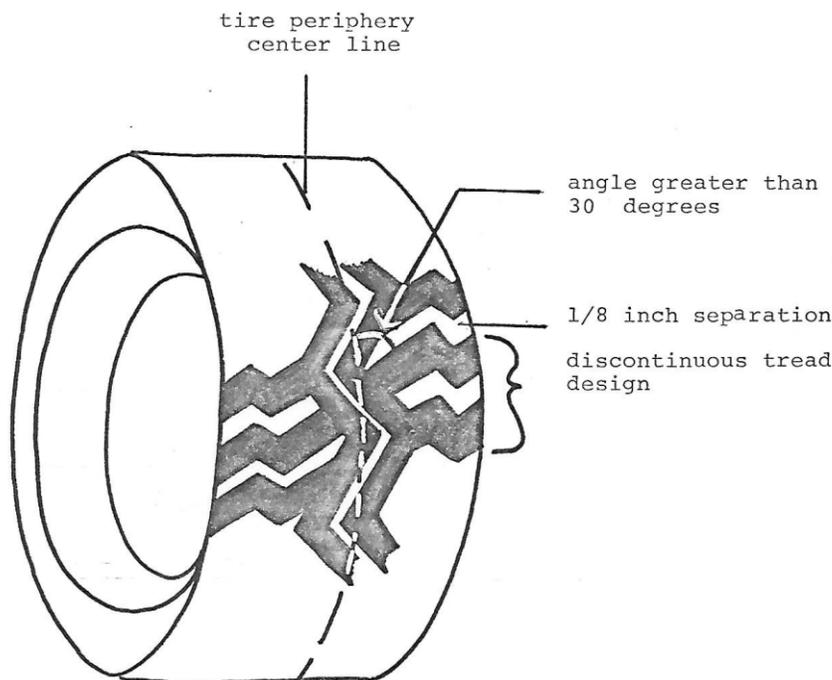
This rule is intended to implement Iowa Code section 321.23.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 5203C, IAB 10/7/20, effective 11/11/20]

761—450.3(321) Mud and snow tire. A mud and snow tire is a tire that is designed to provide additional starting, stopping and driving traction in mud and snow. The tread design shall have ribs, lugs, blocks or knobs which are discontinuous and have a minimum separation of one-eighth of an inch between the ribs, lugs, blocks or knobs. A substantial portion of the rib, lug, block or knob edge in the design of the tread shall be at an angle greater than 30 degrees to the periphery centerline. A mud and snow tire must comply with the tire restrictions expressed in Iowa Code section 321.440.

A tire labeled “Mud and Snow” or any contraction using the letters “M” and “S,” such as “MS,” “M/S,” “M-S” or “M & S” shall be considered a mud and snow tire.

A representation of the distinguishing features of a mud and snow tire is pictured below.



This rule is intended to implement Iowa Code subsection 321.236(12).

761—450.4(321) Minimum requirements for constructing and equipping specially constructed or reconstructed motorcycles or motorized bicycles. Minimum requirements for constructing and equipping specially constructed or reconstructed motorcycles or motorized bicycles as defined in Iowa Code section 321.1 are as follows:

450.4(1) Application. As outlined in rule 761—400.16(321), the applicant shall submit the required application forms and exhibits to the county treasurer. The vehicle and ownership documents shall be examined by the department. If the department determines that the motor vehicle complies with this rule, that the integral parts and components have been identified as to ownership, and that the application forms have been completed properly, the department shall assign an identification number to the vehicle and certify that the motor vehicle is eligible for titling and registration. If the frame specified on an application for a specially constructed or reconstructed motorcycle or motorized bicycle is designated “not for highway use,” the application shall not be approved. The exchange of compatible body parts does not constitute a specially constructed or reconstructed motorcycle or motorized bicycle. The

removal, addition, or substitution of a reconstructed motorcycle or motorized bicycle part that modifies the vehicle's external appearance so that it does not reflect the original make or manufacturer model does constitute a specially constructed, reconstructed, street rod, or replica motorcycle or motorized bicycle. EXEMPTION: The conversion of a manufactured motorcycle from two wheels to three-wheel operation by the addition or substitution of a bolt-on conversion kit shall not constitute a reconstructed motorcycle.

450.4(2) Upgrade pulls—minimum speed. No motor vehicle or combination of vehicles which cannot proceed up a 3 percent grade, on dry concrete pavement, at a minimum speed of 20 miles per hour, shall be operated upon the highways of this state.

450.4(3) Engine. Rescinded IAB 9/8/10, effective 10/13/10.

450.4(4) Frame/chassis. A motorcycle or motorized bicycle frame/chassis, including the suspension components and engine mountings, shall be of sufficient strength, capable of supporting the combined weight of all vehicle components and riders for which the vehicle was designed.

450.4(5) Front end assembly.

a. Trail (extended fork measured in inches). No reconstructed or specially constructed motorcycle or motorized bicycle shall have the front fork so extended as to place the center of the front wheel axle farther than 36 inches from a vertical plane through the steering axis.

b. Rake (extended fork measured in degrees). No reconstructed or specially constructed motorcycle or motorized bicycle shall have the front fork so extended as to exceed a 45-degree angle between the fork assembly and a vertical plane through the steering axis.

c. Extensions. No reconstructed or specially constructed motorcycle or motorized bicycle shall be equipped with extension slugs. However, one-piece extension tubes and springer units, if approved, are acceptable.

d. Wheelbase. No reconstructed or specially constructed motorcycle or motorized bicycle shall have an overall wheelbase, measured from the center of the front axle to the center of the rear axle, of less than 40 inches.

e. Motorcycle front end geometry. A representation of the front end geometry of a motorcycle is depicted in the Appendix to this rule.

450.4(6) Brakes. Every motorcycle and motorized bicycle shall be equipped with at least a rear brake. If the vehicle is also equipped with a front brake, all control cables, lines and hoses shall be located and secured so as not to become pinched between the fork and frame members when the wheel is turned completely to the left or right. Brake-actuating devices shall be in a readily accessible location, unencumbered by vehicle components. A suitable mechanism shall be provided for the purpose of automatically returning the actuating devices to a normal position upon release.

450.4(7) Tires, wheels, rims. Motorcycle tires shall be of pneumatic design with a minimum width of two and twenty-five hundredths inches and designed for highway use. Wheel rim diameters shall not be less than 10 inches and rims shall otherwise comply with applicable federal standards.

450.4(8) Steering and suspension.

a. Stability. Motorcycle or motorized bicycle steering and suspension shall provide the operator with the means of safely controlling vehicle direction.

b. Wheel alignment. The rear wheel of a two-wheel motorcycle or motorized bicycle shall track behind the front wheel within 1 inch with both wheels in a vertical plane when the vehicle is operating on a straight course. On a three-wheel motorcycle or motorized bicycle, the two wheels mounted on the rear axle shall have a wheel track distance not less than 30 inches and the midpoint of the rear wheel track distance shall be within 1 inch of the front wheel track when the vehicle is proceeding on a straight course.

c. Steering.

(1) The steering head shall be provided with a bearing or similar device that will allow the steering shaft to turn freely in rotational motion only. All handlebar-mounted control cables, wires, lines and hoses shall be located and secured so as not to become pinched between the fork and frame members when the wheel is turned completely to the right or the left.

(2) A steering wheel may be used on a three-wheel reconstructed or specially constructed motorcycle or motorized bicycle provided:

1. The steering wheel is circular or nearly circular in shape, having an outside diameter of not less than 13 inches.

2. The steering wheel shall have no less than two turns and no more than six turns when the road wheels are turned from lock to lock.

d. Handlebars. Handlebars shall be of sturdy construction, adequate in size (length) to provide proper leverage for steering, and capable of withstanding a minimum force of 100 pounds applied to each hand grip in any direction. The handlebars shall provide a minimum distance of 18 inches between grips after final assembly.

e. Hand grips. Motorcycles or motorized bicycles shall have handlebars equipped with hand grips of nonslip design or material.

f. Suspension. Motorcycles or motorized bicycles shall be equipped with a suspension system, and the suspension system shall be applicable to at least the front wheel. The suspension system(s) shall be designed for the purpose of maximum vehicle stability.

450.4(9) Fuel system. All fuel system components, including the tank, pump, tubing, hoses, clamps, etc., shall be securely fastened to the motorcycle or motorized bicycle so as not to interfere with vehicle operation and be leakproof when the vehicle is in its normal operating attitude. Fuel lines and tank shall be positioned in a manner so as to prevent their contact with the engine head, manifold, exhaust system, or other high temperature surfaces or moving components. The fuel system shall be adequately vented and provided with a fuel shutoff valve located between the fuel supply and the engine.

450.4(10) Exhaust system. Motorcycles or motorized bicycles with an internal combustion engine shall be equipped with an exhaust system incorporating a muffler or other mechanical device for the purpose of reducing engine noise. Cutouts and bypasses in the exhaust system are prohibited. The system shall be leakproof and all components shall be securely attached to the vehicle and located so as not to interfere with the operation of the motorcycle or motorized bicycle. Shielding shall be provided to prevent inadvertent contact with the exhaust system by the operator and/or passenger during normal operations.

450.4(11) Mirrors. Every motorcycle and motorized bicycle shall be equipped with at least one mirror of unit magnification, securely affixed to the handlebar and capable of adjustment within a range that will reflect an image that includes at least the horizon and the road surface to the rear of the motorcycle or motorized bicycle. The mirror shall consist of a minimum reflective surface of 10 square inches. All mirrors shall be regular in shape (circular, oval, rectangular, or square) and shall not contain sharp edges or projections capable of producing injury.

450.4(12) Fenders. Rescinded IAB 9/8/10, effective 10/13/10.

450.4(13) Seat or saddle. A seat or saddle securely attached to the vehicle shall be provided for the use of the operator. The seat or saddle shall not be less than 20 inches above a level road surface when measured to the lowest point on top of the seat or saddle cushion with the driver seated in a driving position. The seat or saddle adjustment locking device shall prevent relative movement of the seat from its selected and secured position under all normal vehicle operating conditions.

450.4(14) Horn. Every motorcycle and motorized bicycle shall be equipped with at least one horn. The horn shall be electrically operated and shall operate from a control device located on the handlebar. When operated the horn shall be audible for at least 200 feet.

450.4(15) Speedometer and odometer. Every motorcycle and motorized bicycle shall be equipped with a properly operating speedometer and odometer calibrated in miles per hour and miles respectively and shall be fully illuminated when the headlamp(s) is activated.

450.4(16) Lighting equipment. Every motorcycle and motorized bicycle shall be equipped with at least one headlamp but not more than two, mounted securely. Headlamp(s) shall be mounted not less than 24 inches, nor more than 54 inches, above the level road surface. A headlight beam indicator light shall be located within the operator's field of vision and illuminated automatically when the high beam of the headlamp is actuated. Every motorcycle and motorized bicycle shall be equipped with a tail and brake light assembly and a license plate light. All original lamps and lighting equipment provided on the

motor vehicle by the manufacturer shall be maintained in working condition or shall be replaced with equivalent equipment.

450.4(17) Footrest. Every motorcycle shall be equipped with two footrests, one on each side of the vehicle and shall be provided for each designated seating position. Footrests shall be located so as to provide reasonable accessibility. Footrests shall be able to fold upward if they protrude beyond the side of the motorcycle's fixed items. Every motorized bicycle shall be equipped with either two footrests or two pedals, one on each side of the vehicle, to provide reasonable accessibility.

450.4(18) Highway bars. If a motorcycle or motorized bicycle is so equipped, highway bars (alternate footrests) shall be located at a maximum distance of 26 inches from the foot controls and shall not interfere with the operation of the foot controls.

This rule is intended to implement Iowa Code section 321.23.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3108C, IAB 6/7/17, effective 7/12/17; ARC 5203C, IAB 10/7/20, effective 11/11/20]

761—450.5(321) Minimum requirements for constructing and equipping specially constructed or reconstructed autocycles. Minimum requirements for constructing and equipping specially constructed or reconstructed autocycles as defined in Iowa Code section 321.1 are as follows:

450.5(1) Application. As outlined in rule 761—400.16(321), the applicant shall submit the required application forms and exhibits to the county treasurer. The vehicle and ownership documents shall be examined by the department. If the department determines that the autocycle complies with rule 761—450.5(321), that the integral parts and components have been identified as to ownership, and that the application forms have been completed properly, the department shall assign an identification number to the autocycle and certify that the autocycle is eligible for titling and registration. If the frame or unibody specified on an application for a specially constructed, reconstructed, street rod, or replica autocycle is designated “not for highway use,” the application shall not be approved. The exchange of compatible body parts does not constitute a specially constructed, reconstructed, street rod, or replica autocycle. The removal, addition, or substitution of reconstructed autocycle parts that modifies the autocycle's external appearance so that it does not reflect the original make or manufacturer model for that model does constitute a specially constructed, reconstructed, street rod, or replica autocycle.

450.5(2) Seat belt. A seat belt for each seat shall be installed in the autocycle in accordance with Federal Motor Vehicle Safety Standard No. 209.

450.5(3) Seat. A seat that is firmly attached to the autocycle and does not require the operator to straddle or sit astride shall be provided for the use of the operator.

450.5(4) Lighting equipment. Every autocycle shall be equipped with at least one headlamp, at least one taillight, and either a taillight or a separate white light that illuminates the license plate if a taillight does not. All original lamps and lighting equipment provided on the autocycle by the manufacturer shall be maintained in working condition or shall be replaced with equivalent equipment.

450.5(5) Warning devices. Every autocycle shall be equipped with at least one red reflector, either separate or as part of the taillight or taillights.

450.5(6) Brakes. Every autocycle shall be equipped with a braking system, other than a parking brake, in accordance with Iowa Code section 321.431.

450.5(7) Horn. Every autocycle shall be equipped with a horn that shall be electrically actuated and shall emit a sound clearly audible from a distance of 200 feet.

450.5(8) Exhaust system. Each autocycle with an internal combustion engine shall be equipped with a muffler and emission control system in accordance with federal regulation 49 CFR 393.83. When a muffler and emission control system is factory equipped, neither may be removed.

450.5(9) Mirrors. Every autocycle shall be equipped with a mirror that shall consist of a minimum reflective surface of 10 square inches. All mirrors shall be regular in shape (circular, oval, rectangular, or square) and shall not contain sharp edges or projections capable of producing injury.

450.5(10) Tires. Every autocycle shall be equipped with tires that comply with the requirements of Iowa Code section 321.440.

450.5(11) Floor pan. Every auticycle shall be equipped with a floor pan under the entire passenger-carrying compartment. The floor pan shall support the weight of the number of occupants that the auticycle is designed to carry. The floor pan shall be so constructed that it prevents the entry of exhaust fumes.

This rule is intended to implement Iowa Code section 321.23.
[ARC 5203C, IAB 10/7/20, effective 11/11/20]

761—450.6(321) Safety requirements for the movement of implements of husbandry on a roadway. The following standards are minimum safety requirements for the movement of implements of husbandry on a roadway.

450.6(1) Towing standard. No power unit operated by a retail seller or manufacturer shall tow more than one implement of husbandry, except those implements of husbandry that are not self-propelled and are capable of being towed in tandem, from the manufacturer to the retail seller, from the retail seller to the farm purchaser, or from the manufacturer to the farm purchaser.

450.6(2) Equipment standards.

a. Braking. The towing unit or self-propelled implement of husbandry operated upon a highway shall be equipped with a braking device(s) which can control the movement of and stop the vehicle(s). When the vehicle is traveling 20 miles per hour, the braking device shall be adequate to stop the vehicle or vehicles within 30 feet if the gross weight is less than 5000 pounds and 50 feet if the gross weight is 5000 pounds or more.

b. Rearview mirror. The towing vehicle or self-propelled implement of husbandry shall be equipped with a rearview mirror that reflects to the operator a view of the highway for a distance of at least 200 feet to the rear of the vehicle(s). The rearview mirror equipment standard may be met by the use and installation of a temporary rearview mirror.

c. Lighting. The towing or towed vehicle, the rearmost implement of husbandry being towed in tandem, or a self-propelled implement of husbandry shall be equipped with at least one rear taillight which exhibits a red light plainly visible from a distance of 500 feet to the rear. The rear taillight equipment standard may be met by the use and installation of a temporary rear taillight. If an implement of husbandry is being towed by a vehicle which is equipped with brake lights, the towed unit must also have brake lights, constructed and located on the implement of husbandry so as to give a signal of intention to stop. The light shall be red or yellow in color. The signal shall be plainly visible in normal sunlight and at night from a distance of 100 feet to the rear and may be met by the use and installation of a temporary light.

d. Turn signal. The towing or towed vehicle, the rearmost implement of husbandry being towed in tandem, or a self-propelled implement of husbandry shall be equipped with a turn-signal device that operates in conjunction with or separately from the rear taillight. The signal shall be plainly visible and understandable from a distance of 100 feet to the rear. The turn-signal device equipment standard may be met by the use and installation of a temporary turn-signal device.

e. Tires. Pneumatic tires shall not be used if any part of the ply or cord is exposed; if there is any bump, bulge, or separation; if there is a tread design depth of less than one-sixteenth inch; if there is marking “not for highway use” or “unsafe for highway use.”

f. Warning devices. A towing vehicle or self-propelled implement of husbandry shall be equipped with flares, red reflectors or reflective triangles if operated after sunset and before sunrise.

g. Drawbar. When one vehicle is towing another vehicle, the drawbar shall be of sufficient strength to pull the weight towed and shall be fastened to the frame of the towing unit so as to prevent sideway. In addition to the principal connection there shall be a safety chain which shall be fastened so it is capable of holding the towed vehicle if the principal connection fails.

This rule is intended to implement Iowa Code section 321.383.
[ARC 3108C, IAB 6/7/17, effective 7/12/17]

761—450.7(321) Front windshields, windows or sidewings.

450.7(1) Prohibition. Except as provided in Iowa Code section 321.438(2), a person shall not operate on the highway a motor vehicle equipped with a front windshield, a side window to the

immediate right or left of the driver (front side window) or a sidewing forward of and to the left or right of the driver (front sidewing) which is excessively dark or reflective.

450.7(2) Standard of transparency. “Excessively dark or reflective” means that the windshield, front side window or front sidewing does not meet a minimum standard of transparency of 70 percent light transmittance.

450.7(3) Dark window exemption.

a. Effective July 4, 2012, no exemption shall be granted from the minimum standard of transparency set forth in subrule 450.7(2).

b. A motor vehicle fitted with a front windshield, a front side window or a front sidewing with less than 70 percent but not less than 35 percent light transmittance before July 4, 2012, may continue to be maintained and operated with a front windshield, a front side window or a front sidewing with less than 70 percent but not less than 35 percent light transmittance on or after July 4, 2012, so long as the vehicle continues to be used for the transport of a passenger or operator who obtained Form 432020, which documented a medical need for such reduced transparency, and was signed by the person’s physician before July 4, 2012. Form 432020 must be carried at all times in the vehicle to which the exemption applies. At such time as the vehicle is no longer used for the transport of the passenger or operator who is the subject of Form 432020, the exemption expires and may not be renewed. The owner of the vehicle to which the exemption applied must return the vehicle to conformance with the minimum standard of transparency set forth in subrule 450.7(2) within 60 days of expiration of the exemption.

c. “Physician” as used in this rule means a person licensed under Iowa Code chapter 148, 151 or 154.

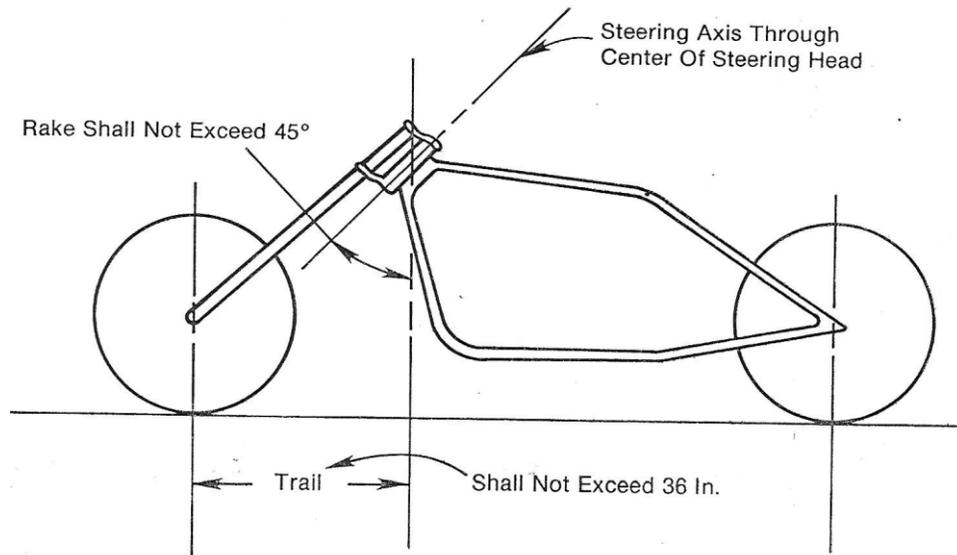
This rule is intended to implement Iowa Code section 321.438.

[ARC 0136C, IAB 5/30/12, effective 7/4/12]

[ARC 6219C, IAB 3/9/22, effective 4/13/22]

APPENDIX TO RULE
761—450.2(321)
Rescinded IAB 9/8/10, effective 10/13/10

APPENDIX TO RULE
761—450.4(321)
MOTORCYCLE FRONT END GEOMETRY



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