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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 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 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.

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[Created by 2003 Iowa Acts, House File 534, section 2]

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CHAPTER 120

CONTRACTUAL LIMITATION OF VENDOR LIABILITY PROVISIONS

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TITLE I
GENERAL DEPARTMENTAL PROCEDURES
CHAPTER 1
DEPARTMENT ORGANIZATION

11—1.1(8A) Creation and mission. The department of administrative services (DAS) is established in Iowa Code chapter 8A. The department manages and coordinates the major resources of state government, including the human, financial, physical and informational resources. The department was created to implement a world-class, customer-focused organization that provides a complement of valued products and services to the internal customers of state government.

The mission of the department is to provide high-quality, affordable infrastructure products and services to its customers—Iowa state government and other government entities—in a manner that allows them to provide better service to the citizens of Iowa and to support the state of Iowa in achieving economic growth.

11—1.2(8A) Location. The department's primary office is located in the Hoover State Office Building, Third Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0150; telephone (515)242-5120. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays. The department's Web site at www.das.iowa.gov provides information about all department organizational units and services.

1.2(1) General services enterprise location. The general services enterprise's primary office is located in the Hoover State Office Building, Level A-South, 1305 East Walnut Street, Des Moines, Iowa 50319; telephone (515)242-5120. Office hours are 7:30 a.m. to 4:30 p.m., Monday through Friday, excluding holidays.

1.2(2) Human resources enterprise location. The human resources enterprise's primary office is located in the Hoover State Office Building, Level A, 1305 East Walnut Street, Des Moines, Iowa 50319-0150; telephone (515)281-3351. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays.

1.2(3) Information technology enterprise location. The information technology enterprise is located in the Hoover State Office Building, Level B, Des Moines, Iowa 50319. The general office telephone number is (515)281-5503. Hours of operation are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays.

1.2(4) State accounting enterprise location. The state accounting enterprise's primary office is located in the Hoover State Office Building, Third Floor, 1305 East Walnut Street, Des Moines, Iowa 50319; telephone (515)281-4877. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays.

1.2(5) Central procurement enterprise location. The central procurement enterprise's primary office is located in the Hoover State Office Building, Third Floor, 1305 East Walnut Street, Des Moines, Iowa 50319; telephone (515)725-2725. Office hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding holidays.

[ARC 1485C, IAB 6/11/14, effective 7/16/14]

11—1.3(8A) Director. The chief executive officer of the department is the director, who is appointed by the governor with the approval of two-thirds of the members of the senate. The director serves at the pleasure of the governor.

The director has the statutory authority to designate an employee of the department to carry out the powers and duties of the director in the absence of the director, or due to the inability of the director to do so.

Specific powers and duties of the department, its director, boards, task forces, advisory panels, and employees are set forth in Iowa Code chapters 8A, 19B, 20, 70A, and 509A and these administrative rules.

11—1.4(8A) Administration of the department. In order to carry out the functions of the department, the following enterprises and bureaus have been established:

1.4(1) General services enterprise. The mission of the general services enterprise is to act as the state's business agent to meet agencies' needs for quality, timely, reliable and cost-effective support services and provide a work environment that is healthy, safe, and well-maintained. The chief operating officer, appointed by the director, heads the general services enterprise. The following bureaus have been established within the general services enterprise:

a. Capitol complex maintenance. The capitol complex maintenance bureau is responsible for the maintenance, appearance, and facility sanitation of the capitol complex buildings and grounds, including environmental control (heating, ventilation and cooling) and all support features including, but not limited to, parking lot maintenance, main electrical distribution, power generation, water supply, utilities, energy efficiency, wastewater removal, on-site safety consultation, work requests for the capitol complex, major maintenance projects associated with the capitol complex, special event coordination, monuments, physical security and access control.

b. Design and construction resources. The design and construction resources bureau provides administration of public improvement projects, including design services, contracting for construction, and construction management oversight for state agencies except any agency of the state exempted by law. Capital funding appropriated to participating state agencies shall be transferred to the design and construction resources bureau for administration. The design and construction resources bureau is responsible for the administration of major maintenance for agencies in accordance with Iowa Code section 8A.302(4).

c. Mail. The mail bureau is responsible for the processing and distribution of mail, which consists of U.S. Mail, UPS, Federal Express, courier service and interoffice mail for the state agencies on the capitol complex and in designated areas in the Des Moines metropolitan area.

d. Service delivery. The service delivery bureau is responsible for the following functions for the enterprise: parking and building access; coordination of events in the public area of the capitol, in other buildings on the capitol complex (excluding the historical building), and on the capitol complex grounds; and providing general information regarding the buildings and grounds on the capitol complex.

e. Real estate services. The real estate services bureau is directly responsible for the management of all leased real estate across the state while also providing real estate consultation services pertaining to acquisition, disposition, and development of real property. Specific services may include market research, opinion of property value, financial analysis, long-term real estate strategy, and project management in accordance with Iowa Code section 8A.321(6). Space planning, including moves, additions, and changes, and surplus property are also coordinated by the bureau.

1.4(2) Human resources enterprise. The human resources enterprise is responsible for human resource management in the executive branch of Iowa state government and provides limited services to the judicial and legislative branches. The mission of the human resources enterprise is to support state agencies in their delivery of services to the people of Iowa by providing programs that recruit, develop, and retain a diverse and qualified workforce, and to administer responsible employee benefits programs for the members and their beneficiaries. The director appoints the chief operating officer of the enterprise. The following bureaus have been established within the human resources enterprise:

a. Benefits. The benefits bureau administers and coordinates the provision of health, dental, life, and disability insurance programs; employee leave programs; workers' compensation, return to work, and loss control and safety programs; 457 deferred compensation; 403(b) tax-sheltered annuity and 401(a) employer match programs; unemployment insurance; and flexible spending and premium conversion programs for state employees.

b. Employment. The employment bureau provides application, referral, recruitment, selection, EEO/AA and diversity services related to state employment; administration of the state classification and compensation programs; and audit of personnel and payroll transactions.

c. Program delivery services. The program delivery services bureau is responsible for employment relations between the state and the certified employee representative; provides consultative services to state departments, boards, and commissions on human resource program matters; provides organization and employee development services including workforce planning and performance evaluation; and represents the state in contested case matters regarding such programs.

1.4(3) Information technology enterprise. The mission of the information technology enterprise is to provide high-quality, customer-focused information technology services and business solutions to government and to citizens. The director appoints the chief information officer for the state, who also serves as the chief operating officer of the enterprise. The following bureaus have been established within the information technology enterprise:

a. Application and E-government services. The application and E-government services bureau is responsible for support of departmental information technology services; providing software applications development, support, and training; and providing advice and assistance in developing and supporting business applications throughout state government.

b. Infrastructure services. The infrastructure services bureau is responsible for providing server systems, including mainframe and other server operations, desktop support, printing and printing procurement services.

c. Integrated Information for Iowa (I/3) project. The I/3 project office provides the strategic direction, functional deployment, and technical support for the I/3 system, including the enterprise accounting, procurement, budget preparation, human resources and payroll functions for the state of Iowa. I/3's vision is to provide greater responsiveness to customers, improved productivity, increased accountability and efficient delivery of services across state government, and consistent and accurate information that Iowans want.

d. Advisory groups.

(1) Technology governance board. The technology governance board operates pursuant to 2005 Iowa Acts, House File 839.

(2) IOWAccess advisory council. The IOWAccess advisory council is established within the department for the purpose of creating and providing to the citizens of this state a gateway for one-stop electronic access to government information and transactions, whether federal, state, or local.

1.4(4) State accounting enterprise. The state accounting enterprise was created to provide for the efficient management and administration of the financial resources of state government. The chief operating officer, appointed by the director, heads the enterprise. The following functional units have been established within the state accounting enterprise:

a. Accounting and daily processing. The accounting and daily processing bureau includes the functions of daily processing, income offset, and financial systems.

b. Other sections. The state accounting enterprise also includes the financial reporting section, the I/3 program team, and the centralized payroll section.

1.4(5) Central administration.

a. Director's office. The director is the chief executive officer for the department. The director's central administration area provides support to the director and to the governmental and business operations of the department and its enterprises. The following functions are included in this area: general counsel; legislative liaison; rules administrator; strategic, performance, and business continuity planning; program oversight and accountability; and departmental and enterprise policy and standards development.

b. Information security office. The information security office is responsible for developing, implementing and maintaining information security policies, standards, and practices that enhance the confidentiality, integrity and availability of computer systems and electronic data resources, and for ensuring enterprise-wide compliance with security requirements. This office includes the chief information security officer for state government.

c. Marketing, communications and council support. Marketing, communications and council support supplies the department's media, public relations, and employee communications services; supports product and service marketing within each of the department's enterprises; and coordinates customer council activities for the department.

1.4(6) Customer management, finance and internal operations. This division provides customer management, finance and internal operations oversight, administration, and support in a manner that provides accurate and timely information, safeguards assets, and facilitates fiscally responsible,

employee-centered and customer-focused decision making for the department. The functional units of the customer management, finance and internal operations division are:

- a. Activity-based costing;
- b. Accounts payable, purchasing, human resources, and administrative support;
- c. Financial reporting and budget; and
- d. Accounts receivable, billing, collections, and customer resource management.

1.4(7) Central procurement and fleet services enterprise. The chief operating officer of the enterprise is appointed by the director and directs the work of the enterprise.

a. The central procurement bureau is charged with procuring goods and services for agencies pursuant to Iowa Code chapter 8A. These rules and applicable Iowa Code sections apply to the purchase of goods and services of general use by any unit of the state executive branch, except any agencies or instrumentalities of the state exempted by law.

b. The central procurement bureau shall manage statewide purchasing and electronic procurement, including managing procurement of commodities, equipment and services for all state agencies not exempted by law.

c. The fleet services bureau is responsible for the management of vehicular risk and travel requirements for state agencies not exempted by law.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

These rules are intended to implement Iowa Code chapter 8A and sections 7E.1 through 7E.5 and 17A.3, and 2005 Iowa Acts, House File 776 and House File 839.

11—1.5 and 1.6 Reserved.

11—1.7(68B) Selling of goods or services. Rescinded IAB 8/16/06, effective 9/20/06.

[Filed emergency 8/29/03—published 9/17/03, effective 9/2/03]

[Filed emergency 10/20/04—published 11/10/04, effective 10/20/04]

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[Filed ARC 2036C (Notice ARC 1969C, IAB 4/15/15), IAB 6/10/15, effective 7/15/15]

TITLE VI
CENTRAL PROCUREMENT

CHAPTER 117

PROCUREMENT OF GOODS AND SERVICES OF GENERAL USE

[Prior to 10/29/03, see 401—Chapters 7, 8, and 9]

[Prior to 8/18/04, see 471—Chapter 13]

[Prior to 8/21/13, see 11—Chapter 105]

11—117.1(8A) General provisions.

117.1(1) Applicability.

a. Goods and services of general use. Under the provisions of Iowa Code chapter 8A, these rules apply to the purchase of goods and services of general use by any unit of the state executive branch including a commission, board, institution, bureau, office, agency or department, except items used by the state department of transportation, institutions under the control of the board of regents, the department for the blind, and any other agencies or instrumentalities of the state exempted by law.

b. Services. Procurement of services shall also meet the provisions of Iowa Administrative Code, 11—Chapters 118 and 119.

c. Information technology. Pursuant to Iowa Code chapter 8A, procurement of information technology devices and services by participating agencies shall also meet the requirements of rule 11—117.11(8A). Rule 11—117.11(8A) shall apply to:

(1) The process by which the department shall ensure effective and efficient compliance with standards prescribed by the department with respect to the procurement of information technology devices and services by participating agencies, and

(2) The acquisition of information technology devices and services by the department for the department or by the department for a participating agency that has requested that the department procure information technology devices or services on the agency's behalf.

117.1(2) Funding. The department and agencies shall follow procurement policies regardless of the funding source supporting the procurement. However, when these rules prevent the state from obtaining and using a federal grant, these rules are suspended to the extent required to comply with the federal grant requirements.

117.1(3) Electronic processing. Notwithstanding other administrative rules, requirements for paper transactions in the procurement of goods and services shall be waived when an alternative electronic process is available. If the vendor is unable to use the electronic process, an alternative paper process may be available.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.2(8A) Definitions.

“Acquisition” or “acquire” is defined in the same manner as “procurement,” “procure,” or “purchase.”

“Agency” or “state agency” means a unit of state government, which is an authority, board, commission, committee, council, department, examining board, or independent agency as defined in Iowa Code section 7E.4, including but not limited to each principal central department enumerated in Iowa Code section 7E.5. However, “agency” or “state agency” does not mean any of the following:

1. The office of the governor or the office of an elective constitutional or statutory officer.
2. The general assembly, or any office or unit under its administrative authority.
3. The judicial branch, as provided in Iowa Code section 602.1102.
4. A political subdivision of the state or its offices or units, including but not limited to a county, city, or community college.

“All or none” means an award based on the total for all items included in the solicitation.

“American-based business” means an entity that has its principal place of business in the United States of America.

“American-made product” means product(s) produced or grown in the United States of America.

“American motor vehicles” means those vehicles manufactured in this state and those vehicles in which at least 70 percent of the value of the motor vehicle was manufactured in the United States or Canada and at least 50 percent of the motor vehicle sales of the manufacturer are in the United States or Canada.

“Award” means the selection of a vendor to receive a master agreement or order of a good or service.

“Bid specification” means the standards or qualities which must be met before a contract to purchase will be awarded and any terms which the director has set as a condition precedent to the awarding of a contract.

“Board” means the technology governance board established by Iowa Code section 8A.204.

“Competent and qualified” means an architect or engineer who, at the sole discretion of the department, has the capability in all respects to satisfactorily perform the scope of services required by the proposed contract in a timely manner.

“Competitive bidding procedure” means the advertisement for, solicitation of, or the procurement of bids; the manner and condition in which bids are received; and the procedure by which bids are opened, accessed, evaluated, accepted, rejected or awarded. A “competitive bidding procedure” refers to all types of competitive solicitation processes referenced in this chapter and may include a transaction accomplished in an electronic format.

“Competitive selection documents” means documents prepared for a competitive selection by a department or agency to purchase goods and services. Competitive selection documents may include requests for proposal, invitations to bid, or any other type of document a department or agency is authorized to use that is designed to procure a good or service for state government. A competitive selection document may be an electronic document.

“Department” means the department of administrative services.

“Director” means the director of the department of administrative services or the director’s designee.

“Emergency” includes, but is not limited to, a condition:

1. That threatens public health, welfare or safety; or
2. In which there is a need to protect the health, welfare or safety of persons occupying or visiting a public improvement or property located adjacent to the public improvement; or
3. In which the department or agency must act to preserve critical services or programs; or
4. In which the need is a result of events or circumstances not reasonably foreseeable.

“Emergency procurement” means an acquisition resulting from an emergency need.

“Enterprise” means most or all state agencies acting collectively, unless it is used in a manner such as “state accounting enterprise,” in which case it means the specific unit of the department of administrative services.

“Fair and reasonable price” means a price that is commensurate with the extent and complexity of the services to be provided and is comparable to the price paid by the department or other entities for projects of similar scope and complexity.

“Formal competition” means a competitive selection process that employs a request for proposals or other means of competitive selection authorized by applicable law and results in procurement of a good or service.

“Good” or *“goods”* means products or personal property other than money that is tangible or movable at the time of purchase, including specially manufactured goods. A contract for goods is a contract in which the predominant factor, thrust, and purpose of the contract as reasonably stated is for the acquisition of goods. When there is a contract for both goods and services and the predominant factor, thrust, and purpose of the contract as reasonably stated is for the acquisition of goods, a contract for goods exists.

“Goods and services of general use” means goods and services that are not unique to an agency’s program or that are needed by more than one agency. This chapter applies to the purchase of goods and services of general use.

“Governmental entity” means any unit of government in the executive, legislative, or judicial branch of government; an agency or political subdivision; any unit of another state government, including its

political subdivisions; any unit of the United States government; or any association or other organization whose membership consists primarily of one or more of any of the foregoing.

“Informal competition” means a streamlined competitive selection process in which a department or agency makes an effort to contact at least three prospective vendors identified by the department or purchasing agency as qualified to perform the work described in the scope of work to request that they provide bids or proposals for the delivery of the goods or services the department or agency is seeking.

“Information technology device” means equipment or associated software, including programs, languages, procedures, or associated documentation, used in operating the equipment which is designed for utilizing information stored in an electronic format. “Information technology device” includes but is not limited to computer systems, computer networks, and equipment used for input, output, processing, storage, display, scanning, and printing.

“Information technology services” means services designed to provide functions, maintenance, and support of information technology devices, or services including but not limited to computer systems application development and maintenance; systems integration and interoperability; operating systems maintenance and design; computer systems programming; computer systems software support; planning and security relating to information technology devices; data management consultation; information technology education and consulting; information technology planning and standards; and establishment of local area network and workstation management standards.

“Iowa-based business” means an entity that has its principal place of business in Iowa.

“Iowa product” means a product(s) produced or grown in Iowa.

“Life cycle cost” means the expected total cost of ownership during the life of a product, including disposal costs.

“Limited scope” means only a few specific services are required for a project. An example is a project for which all existing conditions and parameters are clearly evident or defined in a request for proposal, such as a project calling for development of specifications and bidding documents for replacement of an existing boiler.

“Lowest responsible bidder” means the responsible bidder that is fully compliant with the requirements and terms of the competitive selection document and that submits the lowest price(s) or cost(s).

“Master agreement” means a contract competitively bid and entered into by the department which establishes prices, terms, and conditions for the purchase of goods and services of general use. These contracts may involve the needs of one or more state agencies. Agencies may purchase from a master agreement without further competition. Master agreements (also referred to as “master contracts”) for a particular item or class of items may be awarded to a single vendor or multiple vendors. The department is the sole agency authorized to enter into master agreements for goods and services of general use.

“Material modification” relating to an approved IT procurement means a change in the procurement of 10 percent or \$50,000, whichever is less, or a change of sufficient importance or relevance so as to have possible significant influence on the outcome.

“Negotiated contract” means a master agreement for a procurement that meets the requirements of Iowa Code section 8A.207(4)“b.”

“Newspaper of general circulation” means a newspaper meeting the definition set forth in Iowa Code section 618.3.

“Operational standards” means information technology standards established by the department according to Iowa Code sections 8A.202 to 8A.207 that include but are not limited to specifications, requirements, processes, or initiatives that foster compatibility, interoperability, connectivity, and use of information technology devices and services among agencies.

“Order” means a direct purchase or a purchase from a state contract or master agreement.

“Participating agency,” applicable only to information technology purchases, means any agency other than:

1. The state board of regents and institutions operated under its authority;
2. The public broadcasting division of the department of education;
3. The department of transportation’s mobile radio network;

4. The department of public safety law enforcement communications systems and capitol complex security systems in use for the legislative branch;

5. The Iowa telecommunications and technology commission, with respect to information technology that is unique to the Iowa communications network;

6. The Iowa lottery authority; and

7. A judicial district department of correctional services established pursuant to Iowa Code section 905.2.

“Printing” means the reproduction of an image from a printing surface made generally by a contact impression that causes a transfer of ink, the reproduction of an impression by a photographic process, or the reproduction of an image by electronic means and shall include binding and may include material, processes, or operations necessary to produce a finished printed product, but shall not include binding, rebinding or repairs of books, journals, pamphlets, magazines and literary articles by a library of the state or any of its offices, departments, boards, and commissions held as a part of their library collection.

“Printing equipment” means offset presses, gravure presses, silk-screen equipment, large format ink jet printers, digital printing/copying equipment, letterpress equipment, office copiers and bindery equipment.

“Procurement,” “procure,” or *“purchase”* means the acquisition of goods and services through lease, lease/purchase, acceptance of, contracting for, obtaining title to, use of, or any other manner or method for acquiring an interest in a good or service.

“Procurement authority” means an agency authorized by statute to purchase goods and services.

“Responsible bidder” means a vendor that has the capability in all material respects to perform the contract requirements. In determining whether a vendor is a responsible bidder, the department may consider various factors including, but not limited to, the vendor’s competence and qualification for the type of good or service required, the vendor’s integrity and reliability, the past performance of the vendor relative to the quality of the good or service, the past experience of the department in relation to the vendor’s performance, the relative quality of the good or service, the proposed terms of delivery, and the best interest of the state.

“Sealed” means the submission of responses to a solicitation in a form that prevents disclosure of the contents prior to a date and time established by the department for opening the responses. Sealed responses may be received electronically.

“Service” or *“services”* means work performed for an agency or its clients by a service provider. A contract for services is a procurement where the predominant factor, thrust, and purpose of the contract as reasonably stated is for services. When there is a mixed contract for goods and services, if the predominant factor, thrust, and purpose of the contract as reasonably stated is for service, with goods incidentally involved, a contract for services exists.

“Software” means an ordered set of instructions or statements that causes information technology devices to process data and includes any program or set of programs, procedures, or routines used to employ and control capabilities of computer hardware. As used in these rules, “software” also includes, but is not limited to, an operating system; compiler; assembler; utility; library resource; maintenance routine; application; or a computer networking program’s nonmechanized and nonphysical components; arrangements; algorithms; procedures; programs; services; sequences and routines utilized to support, guide, control, direct, or monitor information technology equipment or applications; and “data processing software” as defined in Iowa Code section 22.3A(1)“e.”

“Sole source procurement” means a purchase of a good or service in which the department or agency selects a vendor without engaging in a competitive selection process.

“Systems software” means software designed to support, guide, control, direct, or monitor information technology equipment, other system software, mechanical and physical components, arrangements, procedures, programs, services or routines.

“Targeted small business (TSB)” means a targeted small business as defined in Iowa Code section 15.102 that is certified by the department of inspections and appeals pursuant to Iowa Code section 10A.104 and as authorized by Iowa Code chapter 73.

“*Upgrade*” means additional hardware or software enhancements, extensions, features, options, or devices to support, enhance, or extend the life or increase the usefulness of previously procured information technology devices.

“*Vendor*” means a person, firm, corporation, partnership, business or other commercial entity that provides services or offers goods for sale or lease.

“*Vendor on-line system*” means a state computer system that enables vendors to conduct business electronically with the state through an Internet location on the World Wide Web.

“*Web*” or “*Web site*” refers to an Internet location on the World Wide Web that provides information, communications, and the means to conduct business electronically.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.3(8A) Competitive procurement. It is the policy of the state to obtain goods and services from the private sector for public purposes to achieve value for the taxpayer through a competitive selection process that is fair, open, and objective. Where feasible, common use items will be purchased cooperatively with state agencies having independent procurement authority to leverage economies of scale, add convenience, standardize common items, and increase efficiencies.

117.3(1) Informal competition. The department may use informal competition or formal competition for the purchase of any good or service or group of goods or services of general use costing less than \$50,000.

117.3(2) Formal competition. The department shall use formal competition for the procurement of any good or service or group of goods or services of general use costing \$50,000 or more.

117.3(3) Construction procurement. Formal competition shall be used for selection of a vendor for construction, erection, demolition, alteration, or repair of a public improvement when the cost of the work exceeds \$100,000 or the adjusted competitive threshold established in Iowa Code section 314.1B.

117.3(4) Purchasing services. Thresholds for the use of formal or informal competition for the procurement of services are governed by rule 11—118.5(8A).

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14]

11—117.4(8A) Master agreements.

117.4(1) Use of master agreements. The department shall enter into master agreements to procure goods and services of general use for all state agencies with the exception of those purchases made by the state department of transportation, institutions under the control of the board of regents, the department for the blind, and any other agencies exempted by law. If the department has entered into a master agreement for a good or service of general use, a state agency that is not otherwise exempt shall purchase the good or service through the master agreement, unless a comparable good or service is available from a different vendor and the quantity required or an emergency or immediate need makes it cost-effective to purchase from that vendor. If an agency or agencies routinely or on a recurring basis purchase a specific good or service not available through a master agreement, the department may establish a master agreement for that good or service in cooperation with the affected agencies.

117.4(2) Term of master agreements. The initial term of a master agreement shall be no more than three years. Following the initial term, a master agreement may be renewed by the department for periods of one to three years; provided, however, that a master agreement, including all optional renewals, shall not exceed a term of six years unless a waiver of this provision is granted pursuant to rule 11—117.21(8A) (goods) or rule 11—118.16(8A) (services).

117.4(3) Master agreements available to governmental subdivisions. Master agreements entered into by the department may be extended to and made available for the use of other governmental entities as defined in Iowa Code section 8A.101. The department shall provide a list of current master agreements to a governmental subdivision upon request. The list may be provided in an electronic format. A governmental subdivision may request a copy of a specific master agreement. The department may provide the master agreement in an electronic format and assess a copying charge when a printed copy is requested.

[ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.5(8A) Exemptions from competitive procurement. The director or designee may exempt goods and services of general use from competitive procurement processes when the procurement meets one of the following conditions. All procurements that are exempt from competitive processes shall be recorded as such, and appropriate justification shall be maintained by the agency initiating the action. Each of the following exemptions from competitive procurement procedures require additional review and approvals.

117.5(1) Emergency procurement.

a. Justification for emergency procurement. An emergency procurement shall be limited in scope and duration to meet the emergency. When considering the scope and duration of an emergency procurement, the department or agency should consider price and availability of the good or service procured so that the department or agency obtains the best value for the funds spent under the circumstances. The department and agencies shall attempt to acquire goods and services of general use with as much competition as practicable under the circumstances.

b. Special procedures required for emergency procurements. Justification for the emergency purchase shall be documented and submitted to the director or designee for approval. The justification shall include the good or service that is to be or was purchased, the cost, and the reasons the purchase should be or was considered an emergency.

117.5(2) Targeted small business (TSB) procurement.

a. Justification for TSB procurement. Agencies may purchase from a TSB without competition for a purchase up to \$10,000.

b. Special procedures for TSB procurements. Agencies must confirm that the vendor is certified as a TSB by the department of inspections and appeals. An agency may contact the TSB directly.

117.5(3) Iowa Prison Industries (IPI) procurement.

a. Justification for IPI procurement. Agencies shall purchase products from IPI or obtain a written waiver in accordance with Iowa Code section 904.808. See <http://www.iaprisonind.com> for IPI catalog. Purchase of standard office modular components and other furniture items shall be in accordance with 11—subrule 100.6(6).

b. Special procedures for IPI purchases. An agency may contact IPI directly.

117.5(4) Procurement based on competition managed by other governmental entities.

a. Justification for procurement based on competition managed by other governmental entities. The department may utilize a current contract, agreement, or purchase order issued by a governmental entity to establish an enterprise master agreement or make a purchase without further competition. The department may join a contract or agreement let by a purchasing consortium when the department reasonably believes it is in the best interest of the enterprise and reasonably believes the contract, agreement, or order was awarded in a fair and competitive manner.

b. Special procedures for procurement based on competition managed by other governmental entities. The department shall notify the other governmental entity and the requesting agency of its intent to use a contract, agreement, or purchase order prior to procuring the good or service in this manner. The department may purchase goods or services from contracts let by other governmental entities provided that the vendor is in agreement and the terms and conditions of the purchase do not adversely impact the governmental entity which was the original signatory to the contract.

117.5(5) Sole source procurement.

a. Justification for sole source procurement. A sole source procurement shall be avoided unless clearly necessary and justifiable. The director or designee may exempt the purchase of a good or service of general use from competitive selection processes when the purchase qualifies as a sole source procurement as a result of the following circumstances:

(1) One vendor is the only one qualified or eligible or is quite obviously the most qualified or eligible to provide the good or service; or

(2) The procurement is of such a specialized nature or related to a specific geographic location that only a single source, by virtue of experience, expertise, proximity, or ownership of intellectual property rights, could most satisfactorily provide the good or service; or

(3) Applicable law requires, provides for, or permits use of a sole source procurement; or

(4) The federal government or other provider of funds for the goods and services being purchased (other than the state of Iowa) has imposed clear and specific restrictions on the use of the funds in a way that restricts the procurement to only one vendor; or

(5) The procurement is an information technology device or service that is systems software or an upgrade, or compatibility is the overriding consideration, or the procurement would prevent voidance or termination of a warranty, or the procurement would prevent default under a contract or other obligation; or

(6) Other circumstances for services exist as outlined in rule 11—118.7(8A).

b. Special procedures required for sole source procurement. For exemption from competitive processes, the requesting agency shall submit to the director justification that the procurement meets the definition of sole source procurement. Use of a sole source procurement does not relieve the department or an agency from negotiating a fair and reasonable price, investigating the vendor's qualifications and any other data pertinent to the procurement, and thoroughly documenting the action. The agency initiating the procurement shall maintain in a file attached to the order the justification and response from the director. The justification, response, and order shall be available for public inspection.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.6(8A) Preferred products and vendors.

117.6(1) Preference to Iowa products and services.

a. All requests for proposals for materials, products, supplies, provisions and other needed articles and services to be purchased at public expense shall not knowingly be written in such a way as to exclude an Iowa-based company capable of filling the needs of the purchasing entity from submitting a responsive proposal.

b. The department and state agencies shall make every effort to support Iowa products when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the Iowa products. Tied bids between Iowa products shall be decided in accordance with subrule 117.13(4).

117.6(2) Preference to Iowa-based businesses. The department and state agencies shall make every effort to support Iowa-based businesses when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the Iowa-based business. Tied bids between Iowa-based businesses shall be decided in accordance with subrule 117.13(4).

117.6(3) American-made products. The department and agencies shall make every effort to support American-made products when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the American-made product. Tied bids between American-made products shall be decided in accordance with subrule 117.13(4).

117.6(4) American-based businesses. The department and agencies shall make every effort to support American-based businesses when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the American-based business. Tied bids between American-based businesses shall be decided in accordance with subrule 117.13(4).

117.6(5) Recycled product and content. The department and agencies shall make every effort to protect Iowa's environment in the procurement of goods. Recycled goods and goods that include recycled content shall be acquired when those goods are available and comparable in quality, performance, and price and there are not other mitigating factors. As required by Executive Order Number 56, the department and agencies shall whenever possible procure durable items that are readily recyclable when discarded, have minimal packaging, and are less toxic.

117.6(6) Products made by persons with disabilities. The department and agencies shall make every effort to procure those products for sale by sheltered workshops, work activity centers, and other special programs funded in whole or in part by public moneys that employ persons with mental retardation, other developmental disabilities, or mental illness if the products meet the required specifications.

117.6(7) Targeted small businesses. The department and agencies may buy from a targeted small business if a targeted small business is able to provide the good or service, pursuant to Iowa Code section

73.20. When enterprise master agreements with targeted small businesses are available, purchases shall be made through these master agreements.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.7(8A) Centralized procurement authority and responsibilities.

117.7(1) *Centralized procurement of goods and services of general use.* The department shall procure goods and services of general use for all state agencies with the exceptions of those purchases made by the state department of transportation, institutions under the control of the board of regents, the department for the blind, and any other agencies exempted by law.

117.7(2) *Delegation of procurement authority.* The department shall establish guidelines for implementation of procurement authority delegated to agencies. The department shall assist agencies in developing purchasing procedures consistent with central purchasing policy and procedures and recommended governmental procurement standards.

117.7(3) *Planning, research, and development.* The director may establish advisory groups and customer councils of agency representatives appointed by the respective agency directors to assist the department in procurement planning and research and to advise on policies, procedures, and financing. This advice includes, but need not be limited to, market research, product specifications, terms and conditions; purchasing rules and guidelines; purchasing system development; and equitable financing of the enterprise purchasing system. The department will provide staff support for any advisory groups and councils that are created.

The department may periodically require forecasts from state agencies and institutions regarding future procurements. When requesting forecasts, the department shall assist agencies in securing and analyzing historical information related to previous purchasing activity.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.8(8A) Notice of solicitations.

117.8(1) *General notification.*

a. Bid posting. The department and each state agency shall provide notice of solicitations. The department and each state agency shall post notice of every formal competitive bidding opportunity and proposal to the official Internet site, <http://bidopportunities.iowa.gov>, operated by the department of administrative services in accordance with Iowa Code sections 73.2, 8A.311, and 362.3. Instead of direct posting, the agency may add a link to <http://bidopportunities.iowa.gov> that connects to the Web site maintained by the agency on which requests for bids and proposals for that agency are posted. For the purposes of this subrule, a formal solicitation is as defined by the appropriate procurement authority. Informal competitive bidding opportunities and proposals may also be posted on or linked to the official state Internet site operated by the department of administrative services.

b. Other forms of notice. Notice of competitive bidding opportunities and proposals may be provided by telephone or fax, in print, or by other means that give reasonable notice to vendors, in addition to the posting or linking of formal solicitations to the official Internet site operated by the department of administrative services.

c. Posting of requests for architectural and engineering services. A request for proposals for architectural or engineering services may be posted electronically by a department or state agency in addition to other methods of advertisement required by law.

d. Bids voided. A formal competitive bidding opportunity that is not preceded by a notice that satisfies the requirements of this subrule is void and shall be rebid. This requirement shall be effective for formal competitive bidding opportunities issued on or after September 1, 2005.

117.8(2) *Targeted small business notification.* Targeted small businesses shall be notified of all solicitations at least 48 hours prior to the general release of the notice of solicitation. The notice shall be distributed to the state of Iowa's 48-hour procurement notice Web site for posting.

117.8(3) *Direct vendor notification.* All procurement opportunities shall be directly communicated to vendors registered through the state's electronic procurement system, Vendor Self-Serve (VSS), if the vendors have indicated an interest in the type of good or service that is the subject of the solicitation. The notice shall be sent to the E-mail or fax or other address entered on VSS by the vendor.

117.8(4) Advertisement of construction procurement. Construction solicitations shall be advertised twice in a newspaper of general circulation published in the county within which the work is to be done when the cost of the work exceeds \$100,000 or the adjusted competitive threshold established in Iowa Code section 314.1B. Additional means of advertisement used shall be consistent with practices in the construction industry. The department may publish an advertisement in an electronic format as an additional method of soliciting bids.

117.8(5) Vendor intent to participate. In the event the department elects to conduct any procurement electronically or otherwise, it may require that vendors prequalify or otherwise indicate their intention to participate in the procurement process.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.9(8A) Types of solicitations. The department may use the following solicitation methods when procuring goods and services of general use for the enterprise.

117.9(1) Informal competition.

a. Description of solicitation. The informal request for bids or proposals may be completed electronically, by telephone or fax, or by other means determined by the department.

b. Response and evaluation. Informal bids shall be tabulated, evaluated, documented and attached to the purchase order.

117.9(2) Formal competition.

a. Description of solicitation. A formal request for bids or proposals shall include:

- (1) Bid due date.
- (2) Time of public bid opening.
- (3) Complete description of commodity needed.
- (4) Buyer's name or code.

b. Response and evaluation. Bids submitted shall be sealed until the date and time of opening. All bids received prior to the date and time set forth on the solicitation will be publicly opened and announced at the designated time and place. All responses shall be documented, evaluated, tabulated and available for public inspection.

117.9(3) Request for bids. A request for bids shall be used to select the lowest responsible bidder from which to purchase goods and services of general use on the basis of price. Vendors may offer goods and services that equal or exceed the state's specifications. Bids that do not meet specifications shall be rejected. The state will not give weight to goods and services offered which exceed specifications. When it is feasible to do so and objective data exists to support the state's decision, the award may be made on a life cycle cost basis.

117.9(4) Requests for proposals.

a. Description of solicitation. The department shall issue a request for proposals whenever a requirement exists for a procurement and cost is not the sole evaluation criterion for selection. The request for proposals shall provide information about a requirement for technical equipment or professional services that is sufficient for the vendor to propose a solution to the requirement. Elements of a request for proposals shall include, but need not be limited to:

- (1) Purpose, intent and background of the requirement.
- (2) Key dates in the solicitation process.
- (3) Administrative requirements for submitting a proposal and format for the proposal.
- (4) Scope of work and performance requirements.
- (5) Evaluation criteria and method of proposal evaluation.
- (6) Contractual terms and conditions.
- (7) Need for a vendor conference.

b. Response and evaluation. Proposals submitted shall be sealed until the date and time of opening. All proposals received prior to the date and time of opening will be opened, and the name of the submitting vendor will be announced. The issuing purchasing officer will review proposals for compliance with requirements before the proposals are submitted for evaluation. A request for

proposals shall be evaluated according to criteria that are developed prior to the issuance of the request for proposal document and that consist of factors relating to technical capability and the approach for meeting performance requirements; competitiveness and reasonableness of price or cost; and managerial, financial and staffing capability.

117.9(5) Best and final offer option.

a. Description of solicitation. The department reserves the right at its sole discretion to conduct a best and final offer process prior to making an award. The best and final offer process shall be conducted after the receipt of responses to a solicitation and prior to publicly releasing the responses. Any best and final offer process shall not allow material modification of the original solicitation requirements or of the evaluation criteria.

The department shall provide to affected vendors instructions that describe in specific terms how the department intends to arrive at the final order or master agreement. The instructions may include modifying the initial offer, updating pricing based on any changes the agency has made, and any added inducements that will improve the overall score in accordance with the evaluation. Other types of solicitations described in this rule may be modified to allow for a best and final offer process.

The department may enter into negotiations with the highest ranked vendor or conduct simultaneous negotiations with a number of the most highly ranked vendors whose total scores are relatively close.

b. Response and evaluation. A best and final offer shall arrive by the due date and time determined by the department and shall be sealed. Evaluation of best and final offers shall be conducted in the same manner as original cost proposals. Scores on the best and final offer shall replace the score achieved on the original proposal.

When negotiating with the highest ranked vendor, the department may accept the vendor's best and final offer or reject the offer and open negotiations with the next highest ranked vendor. The department shall proceed in the same manner in rank order. If the state is unable to negotiate an agreement with the highest ranked vendor, the state may negotiate a best and final offer agreement with another vendor. A best and final offer agreement accepted from a subsequent vendor must be more favorable to the state than the rejected offer or offers.

When negotiating with the highest ranked group of vendors, the department shall request the best and final offer from each. The department shall issue a notice of intent to award that is in the best interest of the enterprise.

117.9(6) Reverse auction.

a. Description of solicitation. The department may purchase goods and services through a reverse auction, a repetitive competitive bidding process that allows vendors to submit one or more bids, with each bid having a lower cost than the previous bid. Notice to vendors shall be given as described in this chapter. The notice shall include the start and ending time for the reverse auction and the method in which it will be conducted.

b. Response and evaluation. Vendors intending to participate shall provide to the department a notice of their intent to participate and of their agreement to provide goods or services equal to or exceeding specifications. The department may require vendors to prequalify to participate in a reverse auction. Prequalification may include a requirement to commit to a baseline price.

117.9(7) Invitation to qualify (ITQ). The department may prequalify vendors and make available to an agency a list of vendors that are capable of providing the requested service.

a. Description of solicitation. The department may prequalify vendors for certain classes of solicitations, including but not limited to:

- (1) Information technology consulting,
- (2) Architectural services, and
- (3) Engineering services.

b. Notification of ITQ solicitation. Following institution of a prequalification process, the department may select, in a competitive manner, a prequalified vendor without public notice and without further negotiation of general terms and conditions. A solicitation may be restricted only to prequalified vendors, in addition to the TSB notification required by subrule 117.8(2).

c. Not an award. Vendor prequalification is not an award and does not create an obligation on the part of the department.

d. Purpose. The department shall use an invitation to qualify process for the purpose of facilitating a subsequent solicitation that uses one of the other methods described in these rules. The purposes of using an invitation to qualify process include but are not limited to the following:

- (1) Standardize state terms and conditions relating to the type of procurement, thereby avoiding repetition and duplication.
- (2) Ensure that prequalified vendors are capable of performing work in a manner consistent with operational standards developed and adopted by the department.
- (3) Implement a pay-for-performance model directly linking vendor payments to defined results as required by Iowa Code section 8.47.
- (4) Consolidate records of vendor qualifications and performance in one location for reference and review.
- (5) Reduce time required for solicitation of proposals from vendors for individual procurements.

e. Evaluation criteria. The department shall develop criteria for vendor qualification based upon its own expertise, the recommendations of its advisors, information and research, and the needs of agencies. The department shall develop and specify evaluation criteria for each invitation to qualify. Examples of evaluation criteria may include but are not limited to the following:

- (1) Affirmative responses to a mandatory agreement questionnaire.
- (2) Ratings of at least average on a professional/technical personnel questionnaire.
- (3) Scores in a specified range for each client reference survey.
- (4) Competitive cost data by type of service.
- (5) Acceptable vendor financial information.

f. Issuance of open invitation.

- (1) The department shall issue invitations to qualify on an as-needed basis.
- (2) The department shall specify the period of time that the invitation to qualify will remain open and the time period for applicability.
- (3) Vendors may apply for eligibility on a continuous basis during the time period that the invitation to qualify remains open.

g. Response and evaluation.

- (1) Vendors seeking to qualify shall be required to meet all the criteria established by the department for a particular category or type of solicitation.
- (2) The department shall continuously evaluate vendor applications for placement on a prequalified-vendor list during the period that the invitation to qualify remains open.

h. Acceptable performance levels.

- (1) The department shall establish and notify prequalified vendors of minimum acceptable performance levels and institute a performance tracking mechanism on each prequalified vendor.
- (2) An approved vendor remains qualified for the period specified by the department unless the vendor does not meet minimum acceptable performance levels.
- (3) If a vendor's performance falls below the minimum acceptable level, the vendor shall be removed from the prequalified list.
- (4) A vendor that does not prequalify or that is removed from the prequalified list due to the vendor's performance has the right to appeal in accordance with rule 11—117.20(8A).

i. Information technology purchases from a prequalified vendor. Before a participating agency may acquire an information technology device or service from a prequalified vendor, the agency must obtain all of the required approvals from the department pursuant to rule 11—117.11(8A).

117.9(8) Other types of solicitations. The department may use other types of competitive solicitations not outlined in these rules if the following conditions are met:

- a.* The solicitation method has been clearly described in public notice.
- b.* The solicitation method includes fair and objective criteria for determining the award.

117.9(9) Request for information (RFI). A request for information (RFI) is a nonbinding method an agency may use to obtain market information from interested parties for a possible upcoming solicitation.

Information may include, but is not limited to, best practices, industry standards, technology issues, and qualifications and capabilities of potential suppliers. Agencies considering the use of an RFI shall contact the department for information and guidance in using this process.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.10(8A) Procurement of architectural and engineering services.

117.10(1) *Qualifications.* As part of the competitive selection process, the department shall determine whether an architect or engineer is competent and qualified. In making this determination, the department may consider the following factors:

1. Professional licensing or registration credentials,
2. Integrity and reliability,
3. Past performance relative to the quality and timeliness of service on similar projects,
4. Past experience with the state in relation to services provided,
5. Quality and timeliness of the services provided,
6. The proposed terms of delivery, and
7. The best interests of the state.

117.10(2) *Fair and reasonable price.* As part of the competitive selection process, the department may request, in addition to the architect's or engineer's qualifications, pricing information that may include a total fee for the specified services, hourly rates, or other pricing measures that will help the department establish a fair and reasonable price.

a. The department shall request a fee proposal(s) as part of the competitive selection process only when the services required are of limited scope, limited duration or otherwise clearly defined. An award shall not be made solely on the basis of the lowest price.

b. When a fee is not requested as part of the competitive selection process, other pricing factors shall be requested, and the firm deemed most qualified will be asked to negotiate a fee using the pricing factors included in the firm's proposal. If a fair and reasonable price for the work cannot be negotiated, the department shall reject the firm's proposal and begin negotiations for a fair and reasonable price with the next most qualified firm.

Examples of fair and reasonable pricing factors include:

- (1) Hourly rates and anticipated hours,
- (2) A lump sum fee,
- (3) Any other costs the department determines to be fair and reasonable.

c. If reimbursable expenses are included in the price proposal, rates shall not exceed those in procedure 210.245, "Travel-in-state—board, commission, advisory council, and task force member expenses," of the department of administrative services state accounting enterprise's Accounting Policy and Procedures Manual.

d. The fee proposal or other pricing information shall serve as a basis for contract negotiations.
[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.11(8A) Procurement of information technology devices and services. This rule applies to the procurement of information technology devices and services by participating agencies.

117.11(1) *Approval of participating agency information technology procurements.*

a. All procurement of information technology devices and services must meet operational standards prescribed by the department.

b. With the exception of requests for proposals (RFPs) which are approved by the technology governance board, procurement of all information technology devices and services, projects and outsourcing of \$50,000 or more or a total involvement of 750 participating agency staff hours or more must receive prior approval from the department of administrative services, information technology enterprise (DAS/ITE), before a participating agency issues a competitive selection document or any other procurement document or otherwise seeks to procure information technology devices or services or both through the department or on its own purchasing authority. The participating agency's approval request shall be in a form prescribed by the department.

c. Participating agencies shall notify the technology governance board in writing on a quarterly basis that technology purchases made during the previous quarter were in compliance with the technology governance board's procurement rules and information technology operational standards.

d. Participating agencies shall not break purchasing into smaller increments for the purpose of avoiding threshold requirements of this subrule.

117.11(2) Review process for proposed procurements.

a. With the exception of requests for proposals (RFPs) which are approved by the technology governance board, the department shall review a proposed information technology procurement of a participating agency regardless of funding source, method of procurement, or agency procurement authority.

b. The department shall review a proposed procurement for compliance with operational standards established by the department.

c. Once procurement is approved, ongoing approval by the department is not required provided that the procurement or scope of work remains consistent with the previously approved procurement or scope of work.

d. Participating agencies shall obtain the department's approval anytime a material modification of the procurement or the scope of work is completed. Review and approval by the department is required prior to implementation of a material modification to a previously approved proposed procurement by a participating agency or by the department on behalf of a participating agency.

e. After approval of the procurement is forwarded to the agency contact person and appropriate procurement authority contacts, the procurement may proceed.

f. When a procurement is not approved, the agency contact will be notified of available options, which include modification and resubmission of the request, cancellation of the request, or requesting a waiver from the director on the recommendation of the technology governance board pursuant to subrule 117.11(3).

g. The department may periodically audit procurements made by a participating agency for compliance with this rule and operational standards of the department. When the audit determines that inconsistencies with established operational standards or with this rule exist, the participating agency shall comply with technology governance board directives to remedy the noncompliance.

h. Information technology devices and services not complying with applicable operational standards shall not be procured by any participating agency unless a waiver is granted by the director on the recommendation of the technology governance board.

i. Upon request by a participating agency, the department may procure, as provided by these rules, any information technology devices or information technology services requested by or on behalf of an agency and accordingly bill the agency through the department's regular process for the information technology devices or information technology services or for the use of such devices or services.

j. The department may provide pertinent advice to a procurement authority or participating agency regarding the procurement of information technology devices or services, including opportunities for aggregation with other procurements.

k. The department shall establish and maintain a Web page (http://das.ite.iowa.gov/standards/enterprise_it/index.html) of current operational standards for information technology devices and services. The Web page shall be updated from time to time with additions, deletions and modifications.

117.11(3) Waiver requests for operational standards.

a. Waiver requests. In the event a participating agency is advised that its proposed procurement is disapproved and the participating agency seeks a waiver of operational standards, it must file its written waiver request with the department within five calendar days of the date of the disapproval. The waiver request shall be filed pursuant to rule 11—25.6(8A).

b. Hearing. The department may conduct a hearing with the participating agency regarding the waiver request. Additional evidence may be offered at the time of the hearing. Oral proceedings shall be recorded either by mechanized means or by a certified shorthand reporter. Parties requesting that

the hearing be recorded by a certified shorthand reporter shall bear the costs. Copies of tapes of oral proceedings or transcripts recorded by certified shorthand reporters shall be paid for by the requester.

c. Burden of proof. The burden of proof is on the participating agency to show that good cause exists to grant a waiver to the participating agency to complete the proposed procurement.

d. The director shall notify the participating agency in writing of the decision to grant or deny the waiver. In the event a waiver is denied, the participating agency may appeal pursuant to Iowa Code section 679A.19.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.12(8A) Specifications in solicitations. All specifications used in solicitations shall be written in a manner that encourages competition.

117.12(1) *Limitations on brands and models.* Specifications shall be written in general terms without reference to a particular brand or model unless the reference is clearly identified as intending to illustrate the general characteristics of the item and not to limit competition. A specific brand or model may be procured only when necessary to maintain a standard required or authorized by law or rule or for connectivity or compatibility with existing commodities or equipment.

117.12(2) *Recycled content and products.* When appropriate, specifications shall include requirements for the use of recovered materials and products. The specifications shall require, at a minimum, that all responses to a solicitation include a product content statement that describes the percentage of the content of the item that is reclaimed material.

The department shall revise specifications developed by agencies if the specifications restrict the use of alternative materials, exclude recovered materials, or require performance standards that exclude products containing recovered materials unless the agency seeking the product can document that the use of recovered materials will impede the intended use of the product.

Specifications shall support the following procurements:

a. Products containing recovered materials, including but not limited to lubricating oils, retread tires, building insulation materials, and recovered materials from waste tires.

b. Bio-based hydraulic fluids, greases, and other industrial lubricants manufactured from soybeans in accordance with Iowa Code section 8A.316.

117.12(3) *Life cycle cost and energy efficiency.* The department and agencies shall utilize life cycle cost and energy efficiency criteria in developing standards and specifications for procuring energy-consuming products.

117.12(4) *All or none solicitations.* A solicitation may specify whether or not responses will be accepted on an all or none basis. Only when this statement appears on the solicitation may it be included in the response. The department may award either by item or by lot, whichever is to the advantage of the enterprise.

117.12(5) *Financial security.* The department may require bid, litigation, fidelity, and performance security as designated in the solicitation documents. When required, a security may be by certified check, cashier's check, certificate of deposit, irrevocable letter of credit, bond, or other security acceptable to the department.

When required, a security shall not be waived. The security provided by vendors shall be retained until all provisions of the solicitation have been met. The security will then be returned to the vendor.

117.12(6) *Vehicle procurement.*

a. Specifications for procurement of all non-law enforcement, light-duty vehicles, excluding those purchased and used for off-road maintenance work or to pull loaded trailers, shall be for flexible fuel vehicles (as defined by Iowa Code section 8A.362(5)) when an equivalent flexible fuel model is available.

b. Use of specifications for hybrid-electric or other alternative fuel vehicles (as defined by Iowa Code section 8A.362(5)) is encouraged. Procurement of hybrid-electric or other alternative fuel vehicles may be dependent upon whether the costs of the vehicle's life cycle are equivalent to a non-alternative fuel vehicle or non-flexible fuel vehicle (a vehicle with a gasoline E10 engine) prior to the year 2010.

c. The life cycle costs of American motor vehicles shall be reduced by 5 percent in order to determine if the motor vehicle is comparable to foreign-made motor vehicles. The life cycle costs of

a motor vehicle shall be determined on the basis of the bid price, the resale value, and the operating costs based upon a useable life of five years or 75,000 miles, whichever occurs first.

d. The average fuel efficiency for new passenger vehicles and light trucks, as defined in paragraph 117.12(6)“a,” that are purchased in a year shall equal or exceed the average fuel economy standard for the vehicles’ model years as published by the United States Secretary of Transportation.

117.12(7) Bulk diesel fuel procurement. Specifications for procurement of all bulk diesel fuel shall ensure that all bulk diesel procured has at least 5 percent renewable content by 2007, 10 percent renewable content by 2008, and 20 percent renewable content by 2010, provided that fuel that meets the American Society for Testing and Materials (ASTM) D-6751 specification is available. Bulk diesel fuel that is used exclusively for emergency generation is exempt from the renewable content requirement.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.13(8A) Awards. The department shall select a vendor on the basis of criteria contained in the competitive selection document.

117.13(1) Intent to award. After evaluating responses to a solicitation using formal competition, the department shall notify each vendor submitting a response to the solicitation of its intent to award to a particular vendor or vendors subject to execution of a written contract(s). Documentation of awards for solicitations using informal competition will be made available to interested parties upon request. This notice of intent to award does not constitute the formation of a contract(s) between the state and successful vendor(s). If a vendor is not registered on the vendor on-line system and does not provide an E-mail address or fax number, the notice will be mailed.

117.13(2) Rejection of bids. The department reserves the right to reject any or all responses to solicitations at any time for any reason. New bids may be requested at a time deemed convenient to the department and agency involved.

117.13(3) Minor deficiencies and informalities. The department reserves the right to waive minor deficiencies and informalities if, in the judgment of the department, the best interest of the state of Iowa will be served.

117.13(4) Tied bids and preferences. If an award is based on the highest score and there is a tied score, or if the award is based on the lowest cost and there is a tied cost, the award shall be determined by a drawing. Whenever it is practical to do so, the drawing will be held in the presence of the vendors with the tied bids. Otherwise, the drawing will be held in front of at least three noninterested parties. All drawings shall be documented.

a. Notwithstanding the foregoing, whenever a tie involves an Iowa vendor and a vendor outside the state of Iowa, first preference will be given to the Iowa vendor. Whenever a tie involves one or more Iowa vendors and one or more vendors outside the state of Iowa, the drawing will be held among the Iowa vendors only. Tied bids involving Iowa-produced or Iowa-manufactured products and items produced or manufactured outside the state of Iowa will be resolved in favor of the Iowa product. If a tied bid does not include an Iowa vendor or Iowa-produced or Iowa-manufactured product, preference will be given to a vendor based in the United States or products produced or manufactured in the United States over a vendor based or products produced or manufactured outside the United States.

b. In the event of a tied bid between Iowa vendors, the department shall contact the Iowa Employer Support of the Guard and Reserve (ESGR) committee for confirmation and verification as to whether the vendors have complied with ESGR standards. Preference, in the case of a tied bid, shall be given to Iowa vendors complying with ESGR standards.

117.13(5) Consideration of life cycle costs. When appropriate to the procurement, life cycle costs shall be considered during the award process.

117.13(6) Trade-ins. When applicable and in the best interest of the state, the department may trade in devices or services to offset the cost of devices or services in a manner consistent with procurement practices to ensure accountability with the state’s fixed asset inventory system.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.14(8A) Agency purchasing authority and responsibilities.

117.14(1) *Purchase of goods.* An agency may acquire goods not otherwise available from a master agreement in accordance with the procurement threshold guidelines in 11—117.15(8A).

117.14(2) *Purchase of services.* An agency may procure services unique to the agency's program or used primarily by that agency and not by other agencies. The department will assist agencies with these procurements upon request. Procurement of services by an agency shall comply with the provisions of 11—Chapters 118 and 119.

117.14(3) *Procurement of printing.*

a. As the first step in the printing procurement process, an agency may provide its request to state printing. State printing may produce the printing internally or procure the printing for the agency.

b. An agency may procure printing. Procurement of printing by an agency shall utilize formal or informal competitive selection, pursuant to 11—117.3(8A). The agency's internal procedures and controls for competitive selection of a printing vendor shall be consistent with the requirements of the department and the state auditor.

117.14(4) *Procurements requiring additional authorization.* Except where exempted by statute, the following purchases require additional approval.

a. Information technology devices, software and services, as required in Iowa Code sections 8A.202 and 8A.206 and rule 11—117.11(8A).

b. Vehicles, as prescribed in Iowa Code sections 8A.361 and 8A.362.

c. Architectural and engineering services, except for agencies with independent authority, as prescribed in Iowa Code sections 8A.302, 8A.311, 8A.321, 218.58, and 904.315.

d. Legal counsel, as prescribed in Iowa Code section 13.7.

e. Telecommunications equipment and services, as required by Iowa Code chapter 8D and the rules of the telecommunications and technology commission.

117.14(5) *Establishment of agency internal procedures and controls.* Agencies shall establish internal controls and procedures to initiate purchases, complete solicitations, make awards, approve purchases, and receive goods. The procedures shall address adequate public recordings of the purchases under the agency's authority consistent with law and rule. Internal controls and security procedures that are consistent with the requirements of the department and state auditor, including staff authority to initiate, execute, approve, and receive purchases, shall be in place for all phases of the procurement.

117.14(6) *Agency receipt of goods.* Agencies receiving goods shall:

a. Inspect or otherwise determine that the goods received meet the specifications, terms and conditions within the order or master agreement,

b. Initiate timely payment for goods meeting specifications, and

c. Document the receipt of goods electronically in a manner prescribed by the department.

All provisions of 11—117.19(8A) shall apply to agency receipt of goods.

117.14(7) *Partial orders.* Agencies may accept partial orders and await additional final receipt or may accept a partial order as a final order. The agency shall notify the vendor of its decision. An agency may pay a vendor a prorated amount for the partial order.

117.14(8) *Items not meeting specifications.* An agency shall not approve final receipt when goods appear not to meet specifications. An agency shall approve final receipt only when satisfied that the goods meet or exceed the specifications and terms and conditions of the order or master agreement. When an agency and vendor are unable to agree as to whether the specifications, terms and conditions are met, the department shall make the decision.

Agencies shall notify the department and the vendor when apparent defects are first noticed. The department will assist the agency with negotiating a satisfactory settlement with the vendor.

117.14(9) *Payment to vendors following final receipt.* An agency shall not unreasonably delay payment on orders for which final receipt is accepted. Except in the case of latent defects in goods, payment to the vendor by the agency signifies agreement by the agency that the goods received are satisfactory. Payment to vendors may be made by any commercially acceptable method, including a state procurement card, in accordance with state financial requirements.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.15(8A) Thresholds for delegating procurement authority.

117.15(1) Agency direct purchasing—basic level. An agency may procure non-master agreement goods costing up to \$1,500 without competition. An agency shall procure non-master agreement goods or services costing between \$1,501 and \$5,000 in a competitive manner, using either informal or formal competition. If an informal process is chosen, the agency shall follow the process described in the definition of “informal competition” in rule 11—117.2(8A). The agency shall document the quotes, or circumstances resulting in fewer than three quotes, in an electronic file attached to the order or in another format.

117.15(2) Agency direct purchasing—advanced level. An agency may procure non-master agreement goods up to \$50,000 per transaction in a competitive manner provided the agency personnel engaged in the purchase of goods have completed enhanced procurement training established by the director or designee.

117.15(3) Preference to targeted small businesses. Agencies shall search the TSB directory on the Web and purchase directly from the TSB source if it is reasonable and cost-effective to do so. Agencies shall comply with the TSB notification requirements in subrule 117.8(2).

117.15(4) Misuse of agency authority.

a. Purchasing authority delegated to agencies shall not be used to avoid the use of master agreements. The agency shall not break purchasing into smaller increments for the purpose of avoiding threshold requirements in subrules 117.15(1) and 117.15(2).

b. As a remedy, the department may recover administrative fees appropriate to the improper execution of procurement.

c. This rule is not intended to prohibit agencies from aggressively seeking competitive prices. Agencies may purchase outside of master agreements under subrule 117.4(1).

d. The department may rescind delegated authority of an agency that misuses its authority or uses the authority to procure goods or services already available on a master agreement.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.16(8A) Printing. This rule provides guidelines for the letting of contracts for public printing by the department and by state agencies, including the enforcement by the department of contracts for printing, except as otherwise provided by law.

117.16(1) Competitive selection for printing. The department and state agencies shall procure printing by competitive selection according to the rules of this chapter except when the printing is produced by state printing, pursuant to rule 11—102.4(8A) or the procurement is otherwise exempt from competitive selection pursuant to rule 11—117.5(8A). When an agency elects to purchase printing by competitive selection rather than using the services of state printing or a TSB, state printing and TSBs shall be part of the bidding process.

117.16(2) Specifications for printing.

a. *Preparation of written specifications.* The department or a state agency shall procure printing by preparing a competitive selection document with written specifications and issue the same to bidders. The bid specifications shall become a part of the printing contract.

b. *Inspection of specifications.* All specifications shall be held on file in the department’s printing division office or the office of the state agency conducting the solicitation and shall be available for inspection by prospective bidders.

117.16(3) Notification of solicitation for printing. The department or a state agency conducting the solicitation shall provide notification of the solicitation for printing to vendors.

117.16(4) Bid bonds for printing.

a. *When applicable.* Security in the form of a bid bond or a certified or cashier’s check may be required from printing vendors.

b. *Amount of bonds.* If a bid bond is required, each formal bid for printing must be accompanied by a certified or cashier’s check for the amount stated in the specifications. An annual bid bond in an amount set by the department may be deposited with the department by the bidder to be used in lieu of

a certified or cashier's check. The amount of the bond is fixed annually and bonds are dated from July 1 to June 30 of the following year.

c. Return of bid bonds. Checks of unsuccessful bidders will be returned when the printed item is contracted. The check of the successful bidder will be returned when the performance bond is received and accepted by the department or by the state agency conducting the solicitation.

d. Performance bonds. When required by the specifications, the successful bidder must deposit with the department or with the state agency conducting the solicitation a performance bond equal to 10 percent of the contract price unless otherwise stated in the specifications. The performance bond must be deposited within 21 days of the date the contract or bond paperwork is issued to the vendor by the department or agency.

e. Forfeiture of bid bond. Failure to enter into a contract by the successful bidder within ten days of the award may result in forfeiture of 10 percent of the bid bond or the certified or cashier's check, if a check is on deposit in lieu of a bond.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.17(8A) Vendor registration and approval. Every vendor wishing to do business with the state shall register as a vendor. Every vendor shall register prior to submitting a response to a solicitation except in the case of an emergency procurement when the vendor shall register prior to filling an order or as soon as practicable. Only properly registered vendors are entitled to payment.

117.17(1) Vendor on-line registration. Vendors are encouraged to register electronically using the vendor on-line system when it becomes available. Vendors that are registered on the vendor on-line system are eligible for all services at the site, including receiving electronic notices of solicitations and submitting an electronic response to a solicitation.

Information from vendors completing registration through the vendor on-line system shall be protected through the use of uniquely identifying information known only to the department and the vendor to confirm the identity of the vendor for all subsequent actions, including responses to solicitations.

The department may take action to restrict or deny use of the vendor on-line system in response to inappropriate use of the site. The department may edit or delete a vendor's posting on the vendor bulletin board if the posting is not appropriate to the business of state purchasing.

117.17(2) Alternate vendor registration. A vendor may register by directly contacting the department or an agency initiating a procurement.

117.17(3) Vendor registration information maintenance. Vendors are responsible for maintaining current and accurate registration information. If registered on the vendor on-line system, the vendor shall update the vendor's account whenever information changes. If registered in an alternate manner, the vendor is responsible for notifying the department or agency of any change in information. This information includes, but is not limited to, company name or type, payment address, procurement address and other contact information.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—117.18(8A) Vendor performance.

117.18(1) Review of vendor performance. The department, in cooperation with agencies, shall periodically, but at least directly prior to renewal of a master agreement, review the performance of vendors. Agencies are encouraged to document vendor performance throughout the duration of the contract and report any problems to the department as they are identified. Performance reviews shall be based on the specifications of the master agreement or order, and shall include, but need not be limited to:

1. Compliance with the specifications,
2. On-time delivery, and
3. Accuracy of billing.

This review will help determine whether the vendor is a responsible bidder for future projects.

117.18(2) *Vendor suspension or debarment.* Prior performance on a state contract may cause a vendor to be disqualified or prevent the vendor from being considered a qualified bidder. In addition, a vendor may be suspended or debarred for any of the following reasons:

- a. Failure to deliver within specified delivery dates without agreement of the department or the agency.
- b. Failure to deliver in accordance with specifications.
- c. Attempts to influence the decision of any state employee involved in the procurement process.
- d. Evidence of agreements by vendors to restrain trade or impede competitive bidding. Such activities shall in addition be reported to the attorney general for appropriate action.
- e. Determination by the civil rights commission that a vendor conducts discriminatory employment practices in violation of civil rights legislation and executive order.
- f. Evidence that a vendor has willfully filed a false certificate with the department.
- g. Debarment by the federal government.

117.18(3) *Correcting performance.* The department shall notify in writing any vendor considered for suspension or debarment and provide the vendor an opportunity to cure the alleged situation. If the vendor fails to remedy the situation after proper notice, the department director may suspend the vendor from eligibility for up to one year or debar the vendor from future business depending on the severity of the violation. The appeal provisions of this chapter shall apply to the decision of the director.

117.18(4) *Remedies for failure to deliver or for delivery of nonconforming goods or services.* If a vendor fails to remedy the situation after the opportunity to cure is provided, the department or agency may procure substitute goods or services from another source and charge the difference between the contracted price and the market price to the defaulting vendor. The attorney general shall be requested to make collection from the defaulting vendor.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—117.19(8A) *General instructions, terms and conditions for vendors.* The following instructions, terms and conditions shall apply to all solicitations unless otherwise stated in the solicitation.

117.19(1) *Instructions for vendors.* The vendor must follow all instructions in the manner prescribed and furnish all information and samples as stated in the solicitation. Minor deficiencies and informalities may be waived if, in the judgment of the department, the best interests of the state will be served.

117.19(2) *Deadline for submission of bid or proposal.* It is the responsibility of the vendor to submit a response to a solicitation according to time, date, and place stated in the solicitation documents. Late responses will be rejected. Unfamiliarity with a geographical location, weather events, labor stoppages, failure of a carrier to meet promised delivery schedules, mechanical failures, and similar reasons are not sufficient justifications for the department to accept a late bid or proposal. At its sole discretion, the department may accept a late response if the delay is due to a catastrophic event and acceptance by the department does not result in an advantage to a competitor.

117.19(3) *Confidential information in a solicitation response.* Unless material submitted in response to a solicitation is identified as proprietary or confidential by the vendor in accordance with Iowa Code section 22.7, all submissions by a vendor are public information. To facilitate a fair and objective evaluation of proposals, submissions by vendors will not be released to competitors or the public prior to issuance of the notice of intent to award. If a vendor's claim of confidentiality is challenged by a competitor or through a request by a citizen to view the proposal, it is the sole responsibility of the vendor to defend the claim of confidentiality in an appropriate venue. The department will not release the subject material while the matter is being adjudicated.

117.19(4) *Recycled products.* A vendor shall be required to include for all applicable procurements a product content statement providing the percentage of the content of the item that is reclaimed material.

117.19(5) *Modifications or withdrawal of a solicitation response.* A solicitation response may be withdrawn or modified prior to the time and date set for opening. Withdrawal or modification requests shall be in writing. With the approval of the director or designee, a bid or proposal may be withdrawn after opening only if the vendor provides prompt notification and adequately documents the commission of an

honest error that might cause undue financial loss. The department may contact a vendor to determine if an error occurred in the vendor's proposal.

117.19(6) Security. The department may require bid or proposal security in accordance with subrule 117.12(5). When required, security shall not be waived.

117.19(7) Assignments. A vendor may not assign an order or a master agreement to another party without written permission from the department.

117.19(8) Strikes, lockouts or natural disasters. A vendor shall notify the department promptly whenever a strike, lockout or catastrophic event prevents the vendor from fulfilling the terms of an order or contract. The department and affected agency may elect to cancel an order or master agreement at their discretion.

117.19(9) Subcontractors or secondary suppliers. Vendors shall be responsible for the actions of and performance of their subcontractors or secondary suppliers. Vendors shall be responsible for payment to all subcontractors or secondary suppliers. Vendors awarded a state construction contract shall disclose the names of all subcontractors within 48 hours after the award of the contract and advise the department of changes in the names of subcontractors throughout the duration of the project.

117.19(10) Material and nonmaterial compliance. At its sole discretion, the department reserves the right to waive technical noncompliance with instructions when such noncompliance, as viewed by a reasonable and prudent person, did not result in an advantage to the vendor submitting the apparent lowest bid or best proposal or would not result in a disadvantage to other vendors submitting competing bids or proposals.

117.19(11) Item and pricing. Price information shall be submitted in response to a solicitation as stated in the instructions. In the case of an error, unit price shall prevail. Unless otherwise stated, all prices shall be submitted with free-on-board (FOB) destination including freight and handling costs.

Prices for one-time purchases must be firm, and preference will be given to firm prices in multiple award contracts. If the department believes it is in the best interest of the state, an economic price adjustment clause based on an acceptable economic indicator may be included in multiple delivery contracts.

a. Price during testing. Items may require testing either before or after the final award is made. In these cases, the vendor must guarantee the price through the completion of testing.

b. Unless otherwise contained in the specifications, all items for which a vendor submits a quotation shall be new, of the latest model, crop year or manufacture and shall be at least equal in quality to those specified.

c. Escalator clauses. Unless specifically provided for in the solicitation document, a response containing an escalator clause that provides for an increase in price will not be considered.

d. Discounts. Only cash discounts that apply to payment terms of 30 days or more will be considered in determining awards. Other payment terms will not be considered. The state will attempt to earn any discounts offered and will compute the period from the latest of the following:

- (1) From date of invoice.
- (2) From the date the complete order is received.
- (3) From the date the vendor's certified invoice is received.

When additional testing of a product is required after delivery, the discount period shall not begin until testing is completed and final approval made.

117.19(12) Notice of intent to award. After evaluating responses to a solicitation, the department shall notify each vendor submitting a response to the solicitation of its intent to award to a particular vendor or vendors subject to execution of a written contract(s). This notice does not constitute the formation of a contract(s) between the state and the vendor(s) to which the notice of intent to award has been issued.

If a vendor is not registered on the vendor on-line system and does not provide an E-mail address or fax number, the notice will be sent by ordinary mail.

117.19(13) Time of acceptance of award. If a time is not stated in the competitive selection document, the vendor may state the length of time that the state has to accept the vendor's offer. This period shall not be less than 10 days for informal quotations or less than 30 days for formal bids. If the

vendor states no minimum time period, the offer shall be irrevocable for 90 days. The department may require a longer evaluation period for technical equipment.

117.19(14) Delivery.

a. Delivery date. A vendor shall show in a response to a solicitation the earliest date on which delivery can be made. The department may include in a solicitation the acceptable delivery date for a commodity. The department may consider delivery dates as a factor in determining to which vendor the notice of intent to award shall be issued. Goods in transit remain the responsibility of the vendor.

b. Notice of rejection. The reason for any rejection of a shipment, based on apparent deficiencies that can be disclosed by ordinary methods of inspection, will be given by the receiving agency to the vendor and carrier within a reasonable time after delivery of the item with a copy of this notice provided to the purchasing section. Notice of latent deficiencies that would make items unsatisfactory for the intended purpose may be given at any time after acceptance.

c. Disposition of rejected item. The vendor must remove at the vendor's expense any rejected item. If the vendor fails to remove the rejected item within 30 days of notification, the department or an agency may dispose of the item by offering it for sale, deduct any accrued expense and remit the balance to the vendor.

d. Testing after delivery. Laboratory analysis of an item or other means of testing may be required after delivery. In such cases, vendors will be notified in writing that a special test will be made and that payment will be withheld until completion of the testing process.

e. Risk of loss or damage. Risk of loss or damage remains with the vendor until delivery and acceptance by the agency at the destination shown on the order.

f. Vendor responsibility for removal of trade-ins. Whenever the purchase of an item of equipment has been made with the trade-in of equipment, it shall be the vendor's responsibility to remove the traded equipment within 30 days of the final acceptance of the purchased equipment by the agency, if not otherwise specified in the competitive selection document. The department or agency will not assume responsibility for equipment that is not removed within this time period and may cause the equipment to be removed by and shipped to the vendor and may bill the vendor for all packing, crating and transportation charges.

117.19(15) Master agreement and purchase order modifications. When consistent with the purpose and intent of the original master agreement or order, amendments or modifications may be issued. All modifications shall be documented and approved by the department or agency and the vendor before modifications take effect. Modifications shall not be used unreasonably to avoid further competition.

117.19(16) Federal and state taxes. The state of Iowa is exempt from the payment of Iowa sales tax, motor vehicle fuel tax and any other Iowa tax that may be applied to a specified commodity or service. A vendor shall be furnished a revenue department exemption letter upon request.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—117.20(8A) Vendor appeals.

117.20(1) Filing an appeal. Any vendor that filed a timely bid or proposal and that is aggrieved by an award of the department may appeal the decision by filing a written notice of appeal before the Director, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319, within five calendar days of the date of award, exclusive of Saturdays, Sundays, and legal state holidays. The department must actually receive the notice of appeal within the specified time frame for it to be considered timely. The notice of appeal shall state the grounds upon which the vendor challenges the department's award.

117.20(2) Procedures for vendor appeal. The vendor appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of the department's administrative rules governing contested case proceedings, unless the provisions of this rule provide otherwise.

a. Notice of hearing. Upon receipt of a notice of vendor appeal, the department shall contact the department of inspections and appeals to arrange for a hearing. The department of inspections and appeals shall send a written notice of the date, time and location of the appeal hearing to the aggrieved vendor or vendors.

The presiding officer shall hold a hearing on the vendor appeal within 60 days of the date the notice of appeal was received by the department.

b. Discovery. The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

c. Witnesses and exhibits. The parties shall contact each other regarding witnesses and exhibits at least 10 days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

d. Amendments to notice of appeal. The aggrieved vendor may amend the grounds upon which the vendor challenges the department's award no later than 15 days prior to the date set for the hearing.

e. If the hearing is conducted by telephone or on the Iowa communications network, the parties must deliver all exhibits to the office of the presiding officer at least 3 days prior to the time the hearing is conducted.

f. The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to all parties by first-class mail.

g. The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

(1) Method of recording. Oral proceedings in connection with a vendor appeal shall be recorded either by mechanized means or by certified shorthand reporters. Parties requesting that certified shorthand reporters record the hearing shall bear the costs.

(2) Transcription. A party may request that oral proceedings in connection with a hearing in a case or any portion of the oral proceedings be transcribed. A party requesting transcription shall bear the expense of the transcription.

(3) Tapes. Parties may obtain copies of tapes of oral proceedings from the presiding officer at the requester's expense.

(4) Retention time. The department shall file and retain the recording or stenographic notes of oral proceedings or the transcription for at least five years from the date of the decision.

117.20(3) Stay of agency action for vendor appeal.

a. When available.

(1) Any party appealing the issuance of a notice of award may petition for stay of the award pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

(2) Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order, and shall state the reasons justifying a stay.

b. When granted. In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

c. Vacation. A stay may be vacated by the issuing authority upon application of the department or any other party.

117.20(4) Review of proposed decision.

a. The proposed decision shall become the final decision of the department 15 days after mailing the proposed decision, unless prior to that time a party submits an appeal of the proposed decision in accordance with the provisions of this subrule.

b. A party appealing the proposed decision shall mail or deliver the notices of appeal to the Director, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. Failure to request review will preclude judicial review unless the department reviews the proposed decision on its own motion. If the department reviews the proposed decision on its own motion, it will send notice of the review to all parties participating in the appeal.

c. A party appealing the proposed decision shall mail a copy of the notice of appeal to all other parties. Any party may submit to the department exceptions to and a brief in support of or in opposition

to the proposed decision within 15 days after the mailing of a notice of appeal or of a request for review. The submitting party shall mail copies of any exceptions or brief it files to all other parties to the proceeding. The director shall notify the parties if the department deems oral arguments by the parties to be appropriate. The director will issue a final decision not less than 30 days after the notice of appeal is filed.

d. The department shall review the proposed decision based on the record and issues raised in the hearing. The department shall not take any further evidence and shall not consider issues that were not raised at the hearing. The issues for review shall be specified in the party's notice of appeal. The party appealing the proposed decision shall be responsible for transcribing any tape of the proceeding before the presiding officer and filing the transcript as part of the record for review. The party appealing the proposed decision shall bear the cost of the transcription regardless of the method used to transcribe the tape.

e. Each party shall have the opportunity to file exceptions to the proposed decision and present briefs in support of or in opposition to the proposed decision. The department may set a deadline for submission of briefs. When the department consents, oral arguments may be presented. A party wishing to make an oral argument shall specifically request it. The department in its sole discretion may schedule oral arguments regarding the appeal. The department shall notify all parties in advance of the scheduled time and place for oral arguments.

f. The director shall issue a final decision by the department. The decision shall be in writing and shall conform to the requirements of Iowa Code chapter 17A.
[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—117.21(8A) Waiver procedure.

117.21(1) *Definition.* For the purpose of this chapter, a “waiver or variance” means an action by the director that suspends, in whole or in part, the requirements or provisions of a rule in this chapter as applied to a state agency when the state agency establishes good cause for a waiver or variance of the rule. For simplicity, the term “waiver” shall include both a “waiver” and a “variance.”

117.21(2) *Requests for waivers.* A state agency seeking a waiver shall submit a written request for a waiver to the director. The written request shall identify the rule for which the state agency seeks a waiver or the contract or class of contracts for which the state agency seeks a waiver and the reasons that the state agency believes justify the granting of the waiver.

117.21(3) *Criteria for waiver.* In response to a request for a waiver submitted by a state agency, the director may issue an order waiving in whole or in part the requirements of a rule in this chapter if the director finds that the state agency has established good cause for the waiving of the requirements of the rule. “Good cause” includes, but is not limited to, the following: (1) the desired good or service is available from one source only, (2) the time frame required is such that an expedient purchase is in the best interest of the agency, or (3) a showing that a requirement or provision of a rule should be waived because the requirement or provision would likely result in an unintended, undesirable, or adverse consequence or outcome. An example of good cause for a waiver is when a contract duration period of longer than six years is more economically or operationally feasible than a six-year contract in light of the service being purchased by the state agency.

[ARC 2036C, IAB 6/10/15, effective 7/15/15]

These rules are intended to implement Iowa Code sections 8A.201 to 8A.203, 8A.206, 8A.207, 8A.301, 8A.302, 8A.311, 8A.341 to 8A.344, 73.1 and 73.2.

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CHAPTER 118
PURCHASING STANDARDS FOR SERVICE CONTRACTS

[Prior to 9/17/03, see 401—Chapter 12]

[Prior to 8/21/13, see 11—Chapter 106]

11—118.1(8A) Authority and scope. This chapter is adopted for the purpose of establishing a system of uniform standards for purchasing services in state government. The department of administrative services has adopted these uniform standards in cooperation with other state agencies.

The rules address when state agencies must use competitive selection to purchase services and when it is acceptable to use a sole source or emergency procurement instead of a competitive selection process. The rules provide a mechanism that allows state agencies to use an informal competitive process for purchases of services when the estimated annual value of the contract is less than \$50,000 and when the estimated value of the multiyear contract in the aggregate, including renewals, is less than \$150,000. The rules also include guidance to state agencies about additional requirements and procedures they should follow when purchasing services.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—118.2(8A) Applicability. This chapter shall apply to all state agencies purchasing services unless otherwise provided by law.

118.2(1) When a state agency that is also a “participating agency” as defined by rule 11—117.2(8A) intends to procure “information technology services” as defined by rule 11—117.2(8A), the provisions of rule 11—117.11(8A) shall also apply to procurement of the services.

118.2(2) When a state agency that is subject to the applicability requirements of rule 11—117.1(8A) intends to procure “services of general use” as defined by rule 11—117.2(8A), the provisions of 11—Chapter 117 shall apply to the procurement.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—118.3(8A) Definitions. For the purposes of this chapter, the following definitions shall apply:

“Agency” or “state agency” means a unit of state government, which is an authority, board, commission, committee, council, department, examining board, or independent agency as defined in Iowa Code section 7E.4, including but not limited to each principal central department enumerated in Iowa Code section 7E.5. However, “agency” or “state agency” does not mean any of the following:

1. The office of the governor or the office of an elective constitutional or statutory officer.
2. The general assembly, or any office or unit under its administrative authority.
3. The judicial branch, as provided in Iowa Code section 602.1102.
4. A political subdivision of the state or its offices or units, including but not limited to a county, city, or community college.

“Competitive selection” means a formal or informal process engaged in by a state agency to compare provider qualifications, terms, conditions, and prices of equal or similar services in order to meet the objective of purchasing services based on quality, performance, price, or any combination thereof. During a competitive selection process, a state agency may weigh the relevant selection criteria in whatever fashion it believes will enable it to select the service provider that submits the best proposal. The lowest priced proposal is not necessarily the best proposal.

“Director” means the director of the department of administrative services or the director’s designee.

“Duration” means the specific length of a service contract.

“Emergency” includes, but is not limited to, a condition:

1. That threatens public health, welfare or safety; or
2. In which there is a need to protect the health, welfare or safety of persons occupying or visiting a public improvement or property located adjacent to the public improvement; or
3. In which the state agency must act to preserve critical services or programs or in which the need is a result of events or circumstances not reasonably foreseeable.

“Emergency procurement” means an acquisition of a service or services resulting from an emergency need.

“Formal competition” means a competitive selection process that employs a request for proposal or other competitive selection process authorized by applicable law resulting in a service contract.

“Informal competition” means a streamlined competitive selection process in which a state agency makes an effort to contact at least three prospective service providers identified by the purchasing state agency as qualified to perform the work described in the scope of work to provide bids or proposals to provide the services the state agency is seeking.

“Intergovernmental agreement” means an agreement for services between a state agency and any other governmental entity whether federal, state, or local and any department, division, unit or subdivision thereof.

“Private agency” or *“private agencies”* means an individual or any form of business organization authorized under the laws of this or any other state or under the laws of any foreign jurisdiction.

“Selection documents” means documents prepared for a competitive selection by a state agency to purchase services. Selection documents may include requests for proposal, invitations to bid, invitations to bid with best value considerations, invitations to qualify, requests for strategy, auctions, reverse auctions, negotiated selection, or any other type of document a state agency is authorized to use that is designed to advise service providers that a state agency is interested in procuring services for state government.

“Service” or *“services”* means work performed for a state agency or for its clients by a service provider and includes, but is not limited to:

1. Professional or technical expertise provided by a consultant, advisor or other technical or service provider to accomplish a specific study, review, project, task, or other work as described in the scope of work. By way of example and not by limitation, these services may include the following: accounting services; aerial surveys; aerial mapping and seeding; appraisal services; land surveying services; construction manager services; analysis and assessment of processes, programs, fiscal impact, compliance, systems and the like; auditing services; communications services; services of peer reviewers, attorneys, financial advisors, and expert witnesses for litigation; architectural services; information technology consulting services; services of investment advisors and managers; marketing services; policy development and recommendations; program development; public involvement services and strategies; research services; scientific and related technical services; software development and system design; and services of underwriters, physicians, pharmacists, engineers, and architects; or

2. Services provided by a vendor to accomplish routine functions. These services contribute to the day-to-day operations of state government. By way of example and not by limitation, these services may include the following: ambulance service; charter service; boiler testing; bookkeeping service; building alarm systems service and repair; commercial laundry service; communications systems installation, servicing and repair; court reporting and transcription services; engraving service; equipment or machine installation, preventive maintenance, inspection, calibration and repair; heating, ventilation and air conditioning (HVAC) system maintenance service; janitorial service; painting; pest and weed control service; grounds maintenance, mowing, parking lot sweeping and snow removal service; towing service; translation services; and travel service.

“Service contract” means a contract for a service or services when the predominant factor, thrust, and purpose of the contract as reasonably stated is for the provision or rendering of services. When there is a contract for both goods and services and the predominant factor, thrust, and purpose of the contract as reasonably stated is for the provision or rendering of services with goods incidentally involved, a service contract exists and these rules apply. *“Service contract”* includes grants when the predominant factor, thrust, and purpose of the contract formalizing the grant is for the provision or rendering of services.

“Service provider” means a vendor that enters into a service contract with a state agency.

“Sole source procurement” means a purchase of services in which the state agency selects a service provider without engaging in a competitive selection process.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—118.4(8A) Intergovernmental agreements. In the event another governmental entity has resources available to supply a service sought by a state agency, the state agency may enter into an

intergovernmental agreement with the other governmental entity and is not required to use competitive selection.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—118.5(8A) Use of competitive selection. State agencies shall use competitive selection to acquire services from private entities when the estimated annual value of the service contract is equal to or greater than \$5,000 or when the estimated value of the multiyear service contract in the aggregate, including any renewals, is equal to or greater than \$15,000 unless there is adequate justification for a sole source or emergency procurement pursuant to rule 11—118.7(8A) or 11—118.8(8A) or another provision of law.

118.5(1) When the estimated annual value of the service contract is equal to or greater than \$50,000 or the estimated value of the multiyear service contract in the aggregate, including any renewals, exceeds \$150,000, a state agency shall use a formal competitive selection process to procure the service.

118.5(2) When the estimated annual value of the service contract is equal to or greater than \$5,000 but less than \$50,000 and the estimated value of the multiyear service contract in the aggregate, including any renewals, does not exceed \$150,000, a state agency, in its sole discretion, shall use either a formal or informal competitive selection process to engage a service provider.

118.5(3) The requirement to use competitive selection to select a service provider when the estimated annual value of the service contract is equal to or greater than \$5,000 or when the estimated value of the multiyear service contract in the aggregate, including renewals, is equal to or greater than \$15,000 applies even when the state agency purchases services from a private entity and designates the contract it enters into with the private entity as a 28E agreement.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—118.6 Reserved.

11—118.7(8A) Sole source procurements.

118.7(1) *When justified.* A sole source procurement shall be avoided unless clearly necessary and justifiable. A state agency may purchase services using a sole source procurement under the following circumstances:

a. A state agency determines that one service provider is the only one qualified or eligible or is quite obviously the most qualified or eligible to perform the service; or

b. The services being purchased involve work that is of such a specialized nature or related to a specific geographic location that only a single source, by virtue of experience, expertise, proximity to the project, or ownership of intellectual property rights, could most satisfactorily provide the service; or

c. A state agency is hiring a service provider to provide peer review services for a professional licensing board pursuant to Iowa Code chapter 272C; or

d. A state agency is hiring the services of experts, advisors, counsel or consultants to assist in any type of legal proceeding including but not limited to testifying or assisting in the preparation of quasi-judicial or judicial proceedings; or

e. The federal government or other provider of funds for the services being purchased (other than the state of Iowa) has imposed clear and specific restrictions on the state agency's use of the funds in a way that restricts the state agency to only one service provider; or

f. Applicable law requires, provides for, or permits use of a sole source procurement.

118.7(2) *Special procedures required for sole source procurements.*

a. When the annual value of the service contract exceeds \$5,000 or when the estimated value of the multiyear service contract in the aggregate, including renewals, is equal to or greater than \$15,000, the director of a state agency or designee shall sign the sole source contract or the amendment. In the absence of the director of a state agency or designee, the sole source contract shall be signed only by the DAS director or designee. Use of sole source procurement does not relieve a state agency from negotiating a fair and reasonable price and thoroughly documenting the procurement action.

b. When the annual value of the service contract exceeds \$5,000 or when the estimated value of the multiyear service contract in the aggregate, including renewals, is equal to or greater than \$15,000, a state agency shall be required to complete a sole source justification form. The director of the state

agency or designee shall sign the sole source justification form. In the absence of the director of the state agency or designee, the sole source justification form shall be signed only by the DAS director or designee. The claim for the first payment on a contract requires a copy of the signed original contract, a copy of the precontract questionnaire, a copy of the sole source justification form, and an original invoice or original claimant signature.

c. The contract for the sole source procurement shall comply with 11—119.4(8,8A), uniform terms and conditions for service contracts, or 11—119.5(8,8A), special terms and conditions.
[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14]

11—118.8(8A) Emergency procurements.

118.8(1) *When justified.* An emergency procurement shall be limited in scope and duration to meet the emergency. When considering the scope and duration of an emergency procurement, the state agency may consider price and availability of the service procured so that the state agency obtains the best value for the funds spent under the circumstances. State agencies should attempt to acquire services with as much competition as practicable under the circumstances.

118.8(2) *Special procedures required for emergency procurements.*

a. The head of a state agency shall sign all emergency contracts and amendments regardless of value or length of term. If the head of a state agency is not available, a designee may sign an emergency contract or amendment. Use of an emergency procurement does not relieve a state agency from negotiating a fair and reasonable price and documenting the procurement action.

b. When the value of the service contract exceeds \$5,000, a state agency shall be required to complete an emergency justification form. The head of the state agency or designee shall sign the emergency justification form.

c. If an emergency procurement results in the extension of an existing contract that contains performance criteria, the contract extension shall comply with rule 11—119.4(8,8A), uniform terms and conditions for service contracts, or rule 11—119.5(8,8A), special terms and conditions.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—118.9(8A) Informal competitive procedures.

118.9(1) When utilizing an informal competition as defined in rule 11—118.3(8A), the state agency may contact the prospective service providers in person, by telephone, fax, E-mail or letter. When the state agency is not able to locate three prospective service providers, the state agency must justify contacting fewer than three service providers. The justification shall be included in the contract file.

118.9(2) A state agency may send copies of the scope of work to service providers that it has identified as qualified to perform the work described in the scope of work.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—118.10 Reserved.

11—118.11(8A) Duration of service contracts.

118.11(1) Each service contract signed by a state agency shall have a specific starting and ending date.

118.11(2) State agencies shall not sign self-renewing service contracts that do not have a specific ending date.

118.11(3) A service contract should be competitively selected on a regular basis so that a state agency obtains the best value for the funds spent, avoids inefficiencies, waste or duplication and may take advantage of new innovations, ideas and technology. A service contract, including all optional renewals, shall not exceed a term of six years; however, service contracts entered into by the office of chief information officer may have a term length not to exceed ten years. Service contracts shall not exceed the term lengths set forth herein unless the state agency obtains a waiver of this provision pursuant to rule 11—118.16(8A).

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—118.12(8A) Additional procedures or requirements.

118.12(1) State agencies, whether utilizing informal or formal competition, shall provide a notice of each procurement for services to the targeted small business Web page located at the Iowa department of economic development's Web site in conformance with Iowa Code section 73.16(2).

118.12(2) Except in an emergency procurement, services shall not be performed pursuant to a service contract for a state agency until all parties to the contract have signed the contract.

118.12(3) At the conclusion of the competitive selection process, all service providers shall be required to sign a service contract.

118.12(4) Each state agency shall maintain a contracting file for each service contract signed by the state agency.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—118.13 and 118.14 Reserved.

11—118.15(8A) Exclusions and limitations.

118.15(1) These rules do not apply to contracts for both goods and services when the predominant factor, thrust, and purpose of the contract as reasonably stated is for the purchase of goods with service incidentally involved. However, in no event shall state agencies designate contracts as contracts for goods to avoid the application of these rules.

118.15(2) Nothing in this chapter is intended to supplant or supersede the requirements adopted by the department of administrative services relating to the processing of claims. State agencies entering into personal services contracts should refer to procedure 240.102, Miscellaneous—Services Contracting, of the department of administrative services, state accounting enterprise policy and procedure manual.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—118.16(8A) Waiver procedure.

118.16(1) For the purpose of this chapter, a “waiver or variance” means an action by the director of the department of administrative services that suspends, in whole or in part, the requirements or provisions of a rule in this chapter as applied to a state agency when the state agency establishes good cause for a waiver or variance of the rule. For simplicity, the term “waiver” shall include both a “waiver” and a “variance.”

118.16(2) Requests for waivers. A state agency seeking a waiver shall submit a written request for a waiver to the director. The written request shall identify the rule for which the state agency seeks a waiver, the contract or class of contracts for which the state agency seeks a waiver, and the reasons that the state agency believes justify granting the waiver.

118.16(3) Criteria for waiver. In response to a request for a waiver submitted by a state agency, the director may issue an order waiving in whole or in part the requirements of a rule in this chapter if the director finds that the state agency has established good cause for waiving the requirements of the rule. “Good cause” includes, but is not limited to, a showing that a requirement or provision of a rule should be waived because the requirement or provision would likely result in an unintended, undesirable, or adverse consequence or outcome. An example of good cause for a waiver is when a contract duration period of longer than six years is more economically or operationally feasible than a six-year contract in light of the service being purchased by the state agency.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—118.17(8A) Effective date. This chapter shall apply to service contracts with a starting date on or after October 1, 2002.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

These rules are intended to implement Iowa Code sections 8A.101, 8A.104, 8A.301, 8A.302, and 8A.311.

[Filed 8/2/02, Notice 4/3/02—published 8/21/02, effective 10/1/02]

[Filed emergency 8/29/03—published 9/17/03, effective 9/2/03]

[Filed 6/2/04, Notice 4/28/04—published 6/23/04, effective 7/28/04]

[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]

[Filed ARC 0952C (Notice ARC 0812C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 1485C (Notice ARC 1302C, IAB 2/5/14), IAB 6/11/14, effective 7/16/14]

[Filed ARC 2036C (Notice ARC 1969C, IAB 4/15/15), IAB 6/10/15, effective 7/15/15]

CHAPTER 120
CONTRACTUAL LIMITATION OF VENDOR LIABILITY PROVISIONS

[Prior to 8/21/13, see 11—Chapter 108]

PREAMBLE

These rules define the process for the department to follow when contracting for information technology goods and services. The rules allow the department to enter into contractual agreements that, in certain instances, will limit the liability of the vendor.

11—120.1(8A) Authority and scope. Pursuant to Iowa Code section 8A.311(21), these rules provide for authorizing information technology procurements containing a contractual limitation of vendor liability as provided for and set forth in the documents initiating the procurement. The department of administrative services adopted these rules in cooperation with the department of management.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—120.2(8A) Definitions.

“*Agency*” or “*state agency*” means a unit of state government, which is an authority, board, commission, committee, council, department, examining board, or independent agency as defined in Iowa Code section 7E.4, including but not limited to each principal central department enumerated in Iowa Code section 7E.5. However, “agency” or “state agency” does not include any of the following:

1. The office of the governor or the office of an elective constitutional or statutory officer.
2. The general assembly, or any office or unit under its administrative authority.
3. The judicial branch, as provided in Iowa Code section 602.1102.
4. A political subdivision of the state or its offices or units, including but not limited to a county, city, or community college.

“*Agency head*” means the director, commissioner, or other official in charge of a state agency.

“*Competitive selection*” means a formal or informal process engaged in by a state agency to compare provider qualifications, terms, conditions, and prices of equal or similar goods or services in order to meet the objective of purchasing goods or services based on quality, performance, price, or any combination thereof.

“*Competitive selection documents*” means documents prepared for a competitive selection by the department or an agency to purchase goods and services. Competitive selection documents may include requests for proposal, invitations to bid, or any other type of document the department or an agency is authorized to use that is designed to procure a good or service for state government. A competitive selection document may be an electronic document.

“*Department*” means the department of administrative services.

“*Director*” means the director of the department of administrative services.

“*Information technology device*” means equipment or associated software, including programs, languages, procedures, or associated documentation designed for the utilization or processing of information stored in an electronic format. “Information technology device” includes but is not limited to computer systems, computer networks, and equipment used for input, output, processing, storage, display, scanning, and printing.

“*Information technology procurement*” means a procurement for goods or services in which the predominant factor, thrust, and purpose of the procurement as reasonably stated is for the purchase of information technology devices or information technology services. Information technology procurements do not include procurements for goods or services in which the purchase of information technology devices or information technology services is an incidental, minor or limited part of the contract.

“*Information technology services*” means services designed to do any of the following:

1. Provide functions, maintenance, and support of information technology devices.
2. Provide services for any of the following:
 - Computer systems application development and maintenance.
 - Systems integration and interoperability.
 - Operating systems maintenance and design.

- Computer systems programming.
- Computer systems software support.
- Planning and security related to information technology devices.
- Data management consultation.
- Information technology education and consulting.
- Information technology planning and standards.
- Establishment of local area network and workstation management standards.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—120.3(8A) Applicability. This chapter applies to information technology procurements conducted by the department, including information technology procurements the department conducts on behalf of another state agency. When the department is conducting an information technology procurement on behalf of another state agency and the procurement exposes the state to risks for which the contractual limitation of vendor liability outlined in rule 11—120.5(8A) is not appropriate, the agency head of the other state agency shall make the decisions regarding contractual limitation of vendor liability outlined in subrule 120.4(2). This chapter does not apply to procurements conducted by another state agency on its own behalf.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—120.4(8A) Authorization of limitation of vendor liability and criteria.

120.4(1) General approach. The director, in consultation with the department of management, may authorize the procurement of information technology devices and services in which a contractual limitation of vendor liability is provided for. Criteria for determining whether to permit a contractual limitation of vendor liability include all of the following:

a. Whether authorizing a contractual limitation of vendor liability is necessary to prevent harm to the state from a failure to obtain the goods or services sought, from obtaining the goods or services at a higher price if the state refuses to allow a contractual limitation of vendor liability, or when the result could be a lower quality good or service.

b. Whether the contractual limitation of vendor liability is commercially reasonable when taking into account any risk to the state created by the goods or services to be procured and the purpose for which they will be used.

120.4(2) Special circumstances. Certain information technology procurements of information technology devices and services expose the state to risks for which the contractual limitation of vendor liability outlined in rule 11—120.5(8A) is not appropriate. The department or applicable agency for which the department is conducting the procurement shall review the risks presented by the particular information technology procurement before initiating the procurement. When either the department or the applicable agency believes a particular information technology procurement may expose the state to risks for which the contractual limitation of vendor liability outlined in rule 11—120.5(8A) is not appropriate, the department or applicable agency shall identify the risks and identify the steps the department or applicable agency believes may help to mitigate the risks. The director or the applicable agency head shall consult with the department of management to determine whether a higher limit of the vendor's contractual liability is appropriate. This determination shall occur before the department issues the competitive selection documents, and the competitive selection documents issued in the procurement shall include the higher limitation on the vendor's contractual liability that the director or the applicable agency head and the department of management have determined to be appropriate for the procurement under consideration.

120.4(3) Applicability. These rules do not apply to procurements for devices or services procured under a federal tariff or using federal funds, if the federal agency providing the funds imposes any requirements regarding limitation of liability provisions in the resulting contract.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—120.5(8A) Prohibited limitation of vendor liability provisions.

120.5(1) For information technology procurements, the director authorizes the competitive selection documents and the resulting contract to include a contractual limitation of vendor liability clause that limits the vendor's liability to one times the contract value, as defined in subrule 120.5(3), provided that the foregoing limitation shall not apply to:

- a.* Intentional torts, criminal acts, fraudulent conduct, intentional or willful misconduct, or gross negligence.
- b.* Claims related to death, bodily injury, or damage to real or personal property.
- c.* Any contractual obligations of the vendor pertaining to indemnification, intellectual property, liquidated damages, compliance with applicable laws, or confidential information.
- d.* Claims arising under provisions of the contract calling for indemnification of the state for third-party claims against the state for bodily injury to persons or for damage to real or tangible personal property caused by the vendor's negligence or willful conduct.

120.5(2) For information technology procurements, the director authorizes the competitive selection documents and the resulting contract to include a contractual limitation of vendor liability clause that limits the vendor's liability for consequential, incidental, indirect, special, or punitive damages to the extent the vendor's liability for such damages does not arise out of the items identified in paragraphs 120.5(1) "a" to "d."

120.5(3) For the purpose of this rule, "contract value" means the aggregate total compensation pertaining to a specific project paid by the state to the vendor under the entire term of the contract including all renewals and extensions.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

11—120.6(8A) Negotiation of limitation of vendor liability provisions.

120.6(1) *After completion of competitive selection process.* In a competitive selection process, the department or the state agency upon whose behalf the department conducts the information technology procurement may either award the contract to the apparent successful vendor without further negotiation or negotiate contract terms, including limitation of vendor liability provisions, if the department or state agency, in its sole discretion, determines that the best interest of the state would be served by entering into negotiations. Any negotiations of vendor limitation of liability contractual provisions shall be done in accordance with the provisions of rules 11—120.4(8A) and 11—120.5(8A).

120.6(2) *Sole source or emergency procurement.* In a justifiable sole source or emergency procurement, the department or state agency may negotiate a contractual limitation of vendor liability provision in accordance with the provisions of rules 11—120.4(8A) and 11—120.5(8A).

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

11—120.7(8A) Additional requirement. Any contract containing a provision limiting the vendor's liability shall also contain provisions limiting the state's liability and preserving the state's sovereign immunity.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

These rules are intended to implement Iowa Code section 8A.311(21).

[Filed 12/22/08, Notice 6/4/08—published 1/14/09, effective 2/18/09]

[Filed ARC 0952C (Notice ARC 0812C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 2036C (Notice ARC 1969C, IAB 4/15/15), IAB 6/10/15, effective 7/15/15]

CHAPTER 90
STATE LICENSED WAREHOUSES
AND WAREHOUSE OPERATORS
[Prior to 7/30/86, Commerce Commission [250], Ch 12]
[Prior to 7/27/88, 21—Ch 60]

21—90.1(203C) Application of rules. These rules are subject to such changes and modifications as the department of agriculture and land stewardship may from time to time deem advisable. These rules are subject to such waivers or variances as may be considered just and reasonable in individual cases, subject to the provisions of 21—Chapter 8.

This rule is intended to implement Iowa Code section 203C.5.

21—90.2(203C) Definitions. For this chapter, the following definitions apply:

“*Bureau*” means the grain warehouse bureau of the department of agriculture and land stewardship.

“*Department*” means the Iowa department of agriculture and land stewardship.

“*Generally accepted accounting principles*” means accounting principles generally accepted in the United States of America, in accordance with the U.S. Financial Accounting Standards Board, or international financial reporting standards, in accordance with the International Accounting Standards Board.

“*Indemnity fund*” means the Iowa grain depositors and sellers indemnity fund created in Iowa Code chapter 203D.

“*Licensee*” means a licensed warehouse operator.

“*Person*” means the same as defined in Iowa Code section 4.1.

“*Provider*” means a person approved by the department to maintain a secure electronic central filing system of electronic warehouse receipt records pursuant to Iowa Code section 203C.18.

“*Provider agreement*” means an agreement required by this chapter which is entered into between the department and a provider.

“*Received*” means the earliest of the following:

1. The date a state warehouse examiner acknowledges receipt.
2. The date stamped “received” in the grain warehouse bureau.
3. The date postmarked, if the item is properly addressed to the Grain Warehouse Bureau, Iowa Department of Agriculture and Land Stewardship, Henry A. Wallace Building, Des Moines, Iowa 50319.

“*United States Warehouse Act*” means the United States Warehouse Act, 7 U.S.C. Ch. 10.

“*USDA*” means the United States Department of Agriculture and its divisions and agencies, including, but not limited to, the Farm Service Agency.

“*USDA Provider Agreement*” means the agreement entered into between the USDA and a provider and which is printed on USDA Form WA-460 and any addenda thereto.

“*User agreement*” means an agreement required by this chapter which is entered into between a provider and a warehouse operator licensed by the department pursuant to the provisions of Iowa Code chapter 203C.

[ARC 7553B, IAB 2/11/09, effective 3/18/09; ARC 9388B, IAB 2/23/11, effective 3/30/11; ARC 0392C, IAB 10/17/12, effective 11/21/12]

21—90.3(203C) Types of products to be warehoused. Products to be warehoused shall be divided into two general types or classes as follows:

90.3(1) Bulk grain, which is grain that is not contained in sacks.

90.3(2) Agricultural and farm consumable products other than bulk grain. Such products include those suitable for storage in quantity, canned agricultural products and products used in producing other agricultural products.

This rule is intended to implement Iowa Code section 203C.1.

21—90.4(203C,203D) Application for a warehouse operator license. Application to operate a licensed warehouse (Iowa Code chapter 203C) shall be made to the bureau on forms prescribed for that

purpose by the bureau. Forms are available from the bureau upon request. All information required by Iowa Code section 203C.7 shall be furnished. The bureau may require the applicant to file updated information if the information on the application is no longer current. The application, insurance certificate, financial statement, tariff, license fee, indemnity fund fee and background information on a person applying for the license and on the managers shall be on file before a license is issued. The bureau chief may require an inspection of the proposed facilities prior to the issuance of a warehouse operator license.

This rule is intended to implement Iowa Code sections 203C.6, 203C.7, 203C.12, 203C.15, 203C.28, 203C.33, 203D.3 and 203D.3A.

[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.5(203C) Warehouse operator license. A warehouse operator license shall specify the type and quantity of products which may be stored in a licensed warehouse. Separate class licenses bearing the same number may be issued to the same business entity authorizing the storage of bulk grain under one license and the storage of products other than bulk grain under the other license (Class 2 warehouse). The separate licenses may be for the same facilities provided the warehouse or warehouses described in the application are suitable for the safe storage of the products intended to be stored.

90.5(1) Warehouse operator license—nontransferable. Warehouse operator licenses are not transferable between different legal entities. Warehouse operator licenses may be amended to cover a name change of the same legal entity. The licensee shall give the bureau notice of a proposed name change. The bureau shall confirm the name change with the secretary of state or other governmental agency prior to amending the license.

90.5(2) Surrender of license. The license shall be surrendered to the bureau immediately upon cancellation, suspension, or revocation of such license.

This rule is intended to implement Iowa Code sections 203C.2, 203C.7, 203C.9 and 203C.16.

[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.6(203C) Posting of license. The warehouse operator license certificate, including the warehouse diagram, shall be posted at all times in a conspicuous location in the place of business. A license certificate shall be posted in each location where grain is delivered or weighed. Upon receipt of an amended license, the warehouse operator shall immediately post the amended license and remove the old license.

This rule is intended to implement Iowa Code section 203C.34.

[ARC 7553B, IAB 2/11/09, effective 3/18/09]

21—90.7(203C) Renewal, expiration and reinstatement of license—payment of license fee.

90.7(1) Renewals. The bureau shall send to each licensed warehouse operator written notice that the application, the license fee and the indemnity fund fee for annual renewal of the warehouse operator license shall be received in accordance with Iowa Code section 203C.37. If the bureau does not receive the application and fees by the due date, the license shall expire. A license that has expired may be reinstated within 30 days of the date of expiration conditioned on the applicant's meeting all statutory requirements and by the bureau's receipt of the following within 30 days of the expiration:

- a. Completed application;
- b. License and indemnity fund fees; and
- c. The reinstatement fee prescribed in Iowa Code section 203C.33.

90.7(2) Proration of fees. Fees for license periods of less than one year shall be prorated on a month-to-month basis. Fees for license periods of less than one year shall be applicable only under the following circumstances:

- a. When an application for a new license is filed; or
- b. When the fiscal year of a license holder is changed.

This rule is intended to implement Iowa Code sections 203C.33 and 203C.37.

[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.8(203C) Financial statements.

90.8(1) *New license applicants.* To obtain a warehouse operator license, an applicant shall submit a financial statement that shall:

- a. Be prepared within three months from the date of filing and comply with 90.8(2), paragraph “a” or “b”; or
- b. Be prepared as of the applicant’s usual fiscal year end and comply with 90.8(2), paragraph “a” or “b,” and the applicant has continuously been in business for one year or more, and the applicant has submitted any additional financial information required by the bureau; or
- c. Be a forecasted financial statement prepared by a certified public accountant licensed in this state, and the applicant is a new business entity that is in the process of transferring funds into the business entity. An applicant who files a forecasted financial statement pursuant to this paragraph shall file a financial statement which complies with 90.8(2), paragraph “a” or “b,” within one month after the date the license is issued by the bureau.

90.8(2) *Financial statement requirements.* Financial statements filed pursuant to subrules 90.8(1), 90.8(3), 90.8(4) and 90.8(11) shall be prepared in accordance with generally accepted accounting principles and shall comply with either of the following:

- a. Be accompanied by an unqualified opinion based upon an audit performed by a certified public accountant licensed in this state. The bureau may accept a qualification in an opinion that is unavoidable by any audit procedure. Opinions that are qualified because of the limited audit procedure or because the scope of an audit is limited shall not be accepted by the bureau; or
- b. Be accompanied by the report of a certified public accountant licensed in this state that is based upon a review performed by the certified public accountant.

90.8(3) *Sole proprietorship financial statements.* An individual licensed as a sole proprietorship shall file a financial statement which conforms with the provisions of subrules 90.8(2) and 90.8(4) on the proprietorship business. The individual shall also file a personal statement of financial condition which conforms with the provisions of subrules 90.8(2) and 90.8(4). The personal statement of financial condition shall also disclose the historical cost basis for assets as provided in Iowa Code section 203C.6.

90.8(4) *Filing date of annual statements.* Every licensee shall prepare financial statements at the close of the licensee’s designated fiscal year and shall file the statements and the bureau’s financial information form with the bureau not later than three months thereafter. These financial statements shall be prepared in accordance with generally accepted accounting principles and shall consist, at a minimum, of a balance sheet, statement of income, statement of cash flow, and accompanying notes to the financial statements. The bureau shall notify every licensee during the month after the close of the licensee’s fiscal year that the licensee’s financial statement is due three months after the close of the licensee’s fiscal year.

90.8(5) *Additional disclosures required in the financial statement.* Unless the following information is disclosed in the fiscal year end financial statements, the licensee’s certified public accountant shall file with the financial statements a separate letter disclosing the information:

- a. A reconciliation of differences in the grain obligations as shown in the financial statement and the daily position record.
- b. Amount and kind of grain on collateral warehouse receipts.
- c. Amount and kind of company-owned grain which is being stored in unlicensed facilities or which has been transferred to another warehouse.
- d. Bushel and dollar amounts of all outstanding grain payables, including a breakdown of the bushels and dollars of each type of credit-sale contract.
- e. Gross grain sales for the fiscal year.
- f. Gross nongrain sales for the fiscal year.
- g. Cost of all goods sold for the fiscal year.
- h. Depreciation expense for the fiscal year.
- i. Interest expense for the fiscal year.
- j. Number of bushels of grain purchased under each grain dealer’s license. For purposes of this paragraph, “purchases” shall mean all grain to which the grain dealer has obtained title during the grain dealer’s fiscal year.

90.8(6) Filing extension.

a. The bureau chief may grant an extension of one month for the filing of financial statements upon receipt of the following:

(1) A letter from the warehouse operator's certified public accountant stating the reason for filing the extension request and that work has been done on preparing the financial statements.

(2) An affidavit from the warehouse operator stating that the warehouse operator meets the financial responsibility requirements of Iowa Code section 203C.6, or that the licensee shall file additional bond in an amount to cover any net worth deficiency as provided in Iowa Code section 203C.6, based upon the licensed certified public accountant's best estimate of the licensee's financial position.

b. Warehouse operators who file false affidavits under this rule may be prosecuted under Iowa Code section 203C.36. Subrule 90.8(6) does not apply to the filing of financial statements required under the provisions of subrules 90.8(10), 90.8(11) and 90.8(12).

90.8(7) Asset valuation. The licensee may submit to the bureau a written request for asset valuation. The written request shall be accompanied by the appraisal and shall have been prepared by a licensed appraiser in this state and shall list the appraiser's credentials. Before an appraisal will be accepted by the bureau, the licensee shall show a positive net worth. All appraisals are subject to approval by the bureau chief. The bureau chief shall notify the licensee within five working days if the appraisal is unacceptable. Any approved asset valuation may be used in any financial statements prepared by or for the licensee in accordance with subrule 90.8(2).

90.8(8) Appraisals. Competent appraisals on file with the bureau shall be valid for use in determining asset value for a maximum period of three years. Thereafter, a new appraisal for asset valuation shall be required and shall be used for a like period of time. In the event the certified public accountant expresses doubt as to the licensee's ability to continue as a going concern, the bureau shall not allow an appraisal to be used to meet net worth requirements. All assets included in the appraisal shall be depreciated by the bureau using the following schedule:

a. Buildings and attached equipment—15 years.

b. Rolling stock (trucks)—5 years.

c. Equipment—5 years.

90.8(9) Assets allowed in meeting financial requirements.

a. *Corporations, limited liability companies and partnerships.* When the bureau determines the net worth for corporations, limited liability companies and partnerships, related party assets that require financial disclosure per financial accounting standards shall be disallowed. These assets shall be excluded unless the licensee can show the bureau sufficient documentation to assure the bureau that the assets are collectible.

b. *Sole proprietors.* When the bureau determines the net worth for sole proprietors, related party assets shall be excluded unless the licensee can show the department sufficient documentation to explain why these assets should be included. Only that part of the value of an asset which is subject to execution shall be allowed by the bureau in determining net worth. When a liability associated with an exempt asset (whether the asset is included or not) exceeds the original cost (or fair market value after an appraisal approved by the bureau), such excess shall be shown as a liability with appropriate footnotes to the financial statement. An applicant or a licensed warehouse operator shall complete the bureau's financial information form regarding this matter and submit the form with the financial statements.

90.8(10) Net worth deficiency monthly financial statements. Every licensee who has a net worth deficiency and who has filed additional bond shall file monthly financial statements with the bureau by the end of the next month until the net worth meets the requirements of Iowa Code section 203C.6 for a minimum of three consecutive months. These financial statements shall contain a minimum of a balance sheet and statement of income and shall be prepared in accordance with generally accepted accounting principles.

90.8(11) Good cause financial statement. The bureau chief may require a licensee to file a financial statement which complies with paragraph 90.8(2) "b" within 45 days of notification by the bureau if one of the following conditions exists:

a. Quantity shortage;

- b. Quality shortage;
- c. Payment is made by use of a check or electronic funds transfer and a financial institution refuses payment because of insufficient moneys in the licensee's account;
- d. Record-keeping violations;
- e. Other documented evidence which indicates that the licensee's financial condition has deteriorated since the filing of the licensee's last financial statement; or
- f. A high risk of loss to the grain depositors and sellers indemnity fund caused by the possible insolvency of the warehouse operator based on a statistical model provided in Iowa Code section 203C.40.

90.8(12) Additional information. The bureau chief may require an applicant or licensee to provide the bureau with any other information reasonably related to the business of a warehouse operator and work papers supporting the financial statements.

90.8(13) Other financial statements. The bureau chief may require a warehouse operator to submit financial statements on a monthly or quarterly basis to verify the operator's financial status or compliance with Iowa Code section 203C.6. These financial statements shall be filed with the bureau by the end of the next month and by the end of every month thereafter until no longer required by the bureau. These financial statements shall contain a minimum of a balance sheet and statement of income and shall be prepared in accordance with generally accepted accounting principles.

90.8(14) Penalty for failure to timely supply financial statements. The department may suspend the license of any warehouse operator who fails to provide the required financial statements within the time limits prescribed by these rules.

This rule is intended to implement Iowa Code sections 203C.1, 203C.5, 203C.6 and 203C.7.
[ARC 9388B, IAB 2/23/11, effective 3/30/11; ARC 1381C, IAB 3/19/14, effective 4/23/14]

21—90.9(203C) Bonds and irrevocable letters of credit. Bonds filed with the bureau shall be on forms prescribed by the bureau. Irrevocable letters of credit filed with the bureau shall be on the form prescribed by the bureau. Bonds and irrevocable letters of credit shall be written so as to provide funds to protect depositors having storage in the warehouse as described in the particular license issued to a warehouse operator.

90.9(1) Agricultural products other than bulk grain. The amount of bond or irrevocable letter of credit to be filed in connection with the storage of agricultural and farm consumable products other than bulk grain shall be determined in accordance with the provisions of Iowa Code section 203C.13. When the net worth of a licensee is less than that required by Iowa Code section 203C.13, the licensee may increase the bond or file an irrevocable letter of credit with the bureau to cover the net worth deficiency as provided by Iowa Code section 203C.13.

90.9(2) Inadequate net worth—storage of bulk grain. When the net worth of a licensee authorized to store bulk grain is less than that required by Iowa Code section 203C.6, the licensee may file a bond or an irrevocable letter of credit with the bureau to cover the net worth deficiency as provided by Iowa Code section 203C.6.

90.9(3) Bond or irrevocable letters of credit as department may require. In addition to the minimum amount as provided by Iowa Code section 203C.13 and in addition to an amount to cover the net worth deficiency as provided by Iowa Code section 203C.6, the bureau chief may require a bond or an irrevocable letter of credit to be filed in an amount determined by the department for any of the following reasons:

- a. Quality deficiency in stored grain;
- b. Quantity deficiency in stored grain;
- c. Use of temporary storage facilities or emergency storage by licensee; or
- d. Documented evidence of the excessive use of lost warehouse receipt release forms by the licensee.

90.9(4) Minimum amount of indemnification. The amount of bond, additional bond, or irrevocable letter of credit prescribed under subrule 90.9(1), 90.9(2) or 90.9(3) is the minimum amount that shall

be accepted by the bureau. A bond or irrevocable letter of credit in a higher amount may be filed if the warehouse operator deems it advisable in the operation of the warehouse business.

90.9(5) *Quality and quantity deficiency bonds.* Quality and quantity deficiency bonds shall be for a minimum of 45 days.

90.9(6) *Replacement bond or irrevocable letter of credit.* The bureau shall send a written notice and information and forms for filing the required replacement bond or irrevocable letter of credit, unless the bond or irrevocable letter of credit is no longer necessary. If the licensee has not filed a replacement bond or irrevocable letter of credit with the bureau within 60 days of receipt of the notice of cancellation, the department shall automatically suspend the warehouse operator license and cause the licensed warehouse to be inspected by the bureau. If the department does not receive a replacement bond or irrevocable letter of credit from the licensee within 30 days of the suspension of the license, the department shall automatically revoke the warehouse operator license and commence an examination of the licensee. When the licensee's failure to file a replacement bond or irrevocable letter of credit causes revocation of the warehouse operator license, the bureau chief shall give notice of such revocation to each holder of an outstanding warehouse receipt and all persons known to have grain retained in open storage.

90.9(7) *Cancellation of bond or irrevocable letter of credit.* The issuer shall send the cancellation notice to the bureau by certified mail. The notice shall be in accordance with the provisions of the bond or irrevocable letter of credit. The time period for notice of cancellation stated in the bond or irrevocable letter of credit commences on the date when the bureau receives the notice. The bureau shall send written acknowledgment of the cancellation of the bond or irrevocable letter of credit to the issuer and the principal.

This rule is intended to implement Iowa Code sections 203C.6, 203C.11, 203C.12 and 203C.13.

21—90.10(203C) Insurance. Each warehouse operator licensed by the department shall keep fully insured, for the current market value, against loss by fire, inherent explosion or windstorm, all agricultural products in storage in the warehouse and all agricultural products which have been deposited temporarily in the warehouse pending storage or for purposes other than storage. This insurance shall be carried in an insurance company or companies authorized to do business in this state and shall be provided by and carried in the name of the warehouse operator. Each policy providing such coverage must have attached thereto an Iowa warehouse endorsement form as prescribed by the department. An insurance policy may include more than one location, and a location may be insured by more than one policy.

90.10(1) *Certificate of insurance.* As evidence that insurance coverage has been provided, the licensee shall file with the department a certificate of insurance form as prescribed by the department.

a. Not more than one policy shall be included on one certificate of insurance.

b. Where one policy provides coverage for two or more licenses or locations and coverage is provided separately at each location, a separate certificate of insurance shall be executed for each license or location shown on the policy. Each certificate shall show the total amount of insurance provided by the policy for the license or locations for which the certificate is provided.

c. Where one policy provides coverage for two or more licenses or locations and coverage is provided on a blanket basis at all locations, one certificate of insurance shall be executed for the policy. The certificate shall show the amount of insurance provided by the policy.

90.10(2) *Cancellation of insurance.* When the department receives notice from an insurance company that the company is canceling the insurance of a licensed warehouse, the department shall send written notice to the warehouse operator. The notice shall explain the department's enforcement action that will result from the warehouse operator's noncompliance. The department shall suspend the warehouse operator license if the department does not receive proof of replacement insurance by the insurance cancellation date. The department shall immediately conduct an inspection of the licensed warehouse upon suspension of the license. If replacement insurance is not filed within 10 days following suspension, the department shall revoke the warehouse operator license. When the department revokes a license, the department shall notify each holder of an outstanding warehouse receipt and all known persons who have grain retained in open storage of the revocation. The department shall further notify

each receipt holder and all known persons who have grain retained in open storage that the grain must be removed from the warehouse not later than the thirtieth day following the revocation. The notice shall be sent by ordinary mail to the last-known address of each person having grain in storage.

90.10(3) *Expiration of insurance.* The department shall send the warehouse operator a reminder letter 30 days prior to the effective date of the expiration of the insurance of a licensed warehouse. The notice shall explain the department's enforcement action that will result from the warehouse operator's noncompliance. The department shall suspend the warehouse operator license if replacement insurance is not received by the department by the expiration date. The department shall immediately conduct an inspection of the licensed warehouse upon suspension of the license. If the licensee does not file replacement insurance within 10 days following suspension, the department shall revoke the warehouse operator license. When the department revokes a license, the department shall notify each holder of an outstanding warehouse receipt and all known persons who have grain retained in open storage that the license has been revoked. The department shall further notify each receipt holder and all persons who have grain retained in open storage that the grain must be removed from the warehouse not later than the thirtieth day following the revocation. The notice shall be sent by ordinary mail to the last-known address of each person having grain in storage.

90.10(4) *Insufficient insurance.* The department shall provide written notice to the warehouse operator when the department has evidence that the value of commodities in the warehouse is greater than the limit of liability of the insurance policy. The notice shall explain the department's enforcement action that will result from the warehouse operator's noncompliance. The department shall suspend the warehouse operator license if the department does not receive proof of sufficient insurance coverage within 30 days of the notice. The department shall immediately conduct an inspection of the licensed warehouse upon suspension of the license. If the warehouse operator does not provide proof of sufficient insurance coverage within 10 days of the license suspension, the department shall revoke the license. When the department revokes the license, the department shall notify each holder of an outstanding warehouse receipt and all known persons who have grain retained in open storage that the license has been revoked. The department shall further notify each receipt holder and all persons who have grain retained in open storage that the grain must be removed from the warehouse not later than the thirtieth day following the revocation. The notice shall be sent by ordinary mail to the last-known address of each person having grain in storage.

This rule is intended to implement Iowa Code section 203C.15.
[ARC 0392C, IAB 10/17/12, effective 11/21/12]

21—90.11(203C) Notice to the warehouse bureau.

90.11(1) The licensee shall notify the bureau prior to:

- a. Change of ownership of a warehouse.
- b. Change in name or business address of a warehouse or warehouse operator.
- c. The use of additional storage facilities which are not covered under the warehouse operator license.
- d. The use of any facility under the warehouse operator license for storage of a product other than that for which it is licensed.
- e. The changing of the licensee's fiscal year.
- f. Using any bin or facility which has had a structural change.
- g. The ceasing of operations.

90.11(2) The licensee shall notify the bureau within 24 hours after the licensee knows or should have known any of the following:

- a. Loss or damage to stored products or to licensed storage facilities;
- b. Licensee's net worth falling below the amount required by Iowa Code section 203C.6 and if the amount of the deficiency is not covered by a net worth deficiency bond as required by Iowa Code section 203C.6; or
- c. Any quality or quantity deficiency of grain.

90.11(3) The licensee shall notify the bureau within ten days after the licensee knows or should have known any of the following:

- a. Termination of a lease on storage facilities, or the leasing of a facility under license to any other person;
- b. The death of an individual or any member of a partnership operating a warehouse; or
- c. Any change in management.

This rule is intended to implement Iowa Code sections 203C.2, 203C.6, 203C.8 and 203C.9.
[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.12(203C) Issuance of warehouse receipts. A warehouse receipt shall be issued no later than the close of the next business day following demand by the depositor or depositor's agent or, in absence of such demand, the warehouse receipt shall be issued within 12 months from date of deposit in the warehouse, unless the warehouse operator is in possession of a signed and dated statement from the depositor that the depositor does not want a warehouse receipt to be issued. Such waiver shall apply only to grain deposited in the warehouse prior to the date of the waiver.

90.12(1) Waiver. The waiver shall contain a minimum of the following information:

- a. Depositor's name.
- b. Depositor's signature.
- c. Date of deposit.
- d. Date of depositor's signature.
- e. Number of bushels.
- f. Type of commodity.

The waiver must be signed within 12 months of the first delivery of the grain under waiver. If a depositor signs a statement that no warehouse receipt need be issued, such grain shall then be deemed as open storage and shall remain a warehouse obligation. A copy of this statement shall be maintained in the warehouse operator's records. The original (white) warehouse receipt shall be given to the depositor upon demand. The depositor's copy (green) shall be given to the depositor upon issuance of the warehouse receipt. The warehouse operator's copy (yellow) shall be maintained by the warehouse operator in a separate file in numerical order while the warehouse receipt is outstanding.

90.12(2) Unpriced grain deemed held for storage after 30 days. Any grain received at any warehouse for which the actual sale price is not fixed and documented on the warehouse operator's records or for which payment is not made on the thirtieth day shall be construed to be grain held for storage within the meaning of Iowa Code chapter 203C. The 30-day provision is applicable only when there has been no commitment for storage by the depositor, or the warehouse operator fails to have a policy posted in a conspicuous location in the place of business. Grain shall be considered as storage in less than 30 days if the receiving warehouse operator has a policy specifying when such grain shall be considered as storage. Such policy shall be posted at all times in a conspicuous location in the place of business. Warehouse receipts shall be issued in accordance with the provisions of Iowa Code section 203C.18. Grain held in storage after the thirtieth day or after the time period less than 30 days in accordance with the warehouse operator's posted policy for which warehouse receipts have not been issued shall be considered as open storage. The warehouse operator's tariff charges shall apply to open storage from date of deposit. Open storage shall be considered as a storage obligation.

90.12(3) Information on warehouse receipts. Not more than one product, or grade, or value of product shall be shown on a warehouse receipt. All grade factors pertinent to determining grade shall be shown on warehouse receipts issued for bulk grain, and any other information pertinent to the product, stored under warehouse receipt, should clearly be stated under the heading "Remarks." The warehouse operator, in the inspection of the grain upon delivery, shall perform a sufficient amount of sampling of the grain to ensure a representative application of the grade factors to the grain. All warehouse receipts issued shall designate the person to whom the receipt is issued and whether it is issued negotiable or nonnegotiable.

a. All warehouse receipts shall be issued on an accurate and complete basis. All applicable areas shall be filled in. Any of the following errors shall be cause to cancel and reissue the warehouse receipt:

- (1) Illegible changes or appearance of change in overall amount;
- (2) Change in the type of grain; or
- (3) Changing the warehouse receipt from negotiable to nonnegotiable or vice versa.

b. Any alterations not directly prohibited shall be made by strike-through and replacement. No correction material shall be used. The person making the change shall initial and date the change. All copies shall be altered identically.

90.12(4) *Restrictions on the issuance of collateral warehouse receipts.* Collateral receipts cannot be issued for grain represented by credit-sale contract except for the percentage of bushels paid for through advances to sellers on grain purchased by credit-sale contract. The amount and percentage of advances shall be shown on the face of the credit-sale contract or on a listing which identifies the contracts and the amount of the advances.

This rule is intended to implement Iowa Code sections 203C.17 and 203C.18.

21—90.13(203C) Cancellation of warehouse receipts. Upon delivery of the product represented by a warehouse receipt, the original receipt shall be marked “canceled,” signed or initialed, and dated upon the face thereof by the warehouse operator or an authorized agent. The warehouse operator shall then retain possession of the warehouse receipt in a separate numerical order of receipts canceled by the licensee but not yet marked with the warehouse bureau’s stamp and shall present the receipt to be canceled with the department’s stamp at the time of any inspection or examination of the warehouse records. Cancellation shall mean that the obligation is removed from the bureau’s records. The warehouse operator shall, upon request of the bureau, forward any such warehouse receipts to the bureau’s office to be canceled with the department’s stamp. Before the bureau stamps the receipt “canceled” with the department’s stamp, any negotiable receipts which have been used as collateral by the licensee shall have the lender’s release date and signature on the reverse side indicating when the receipt was released.

90.13(1) *Partial delivery of negotiable warehouse receipted commodity.* If only a portion of the product represented by a negotiable warehouse receipt is delivered, such warehouse receipt shall be signed or initialed, dated and marked “canceled” by the warehouse operator or an authorized agent upon the face thereof. A new (or replacement) warehouse receipt shall be issued covering the balance of the product remaining in storage the same day as the original warehouse receipt is canceled. This replacement warehouse receipt, in the space provided under the “Remarks,” shall be marked “Balance of warehouse receipt No. _____,” and the canceled warehouse receipt number shall be inserted in that space.

90.13(2) *Voided warehouse receipts.* Original warehouse receipts voided on the day of issuance by the warehouse operator for any reason shall be so marked, signed or initialed, and dated and held to be stamped with the department’s cancellation stamp in the same manner as any other warehouse receipt.

90.13(3) *Warehouse receipt cancellation procedure.*

- a. The warehouse operator shall have the original warehouse receipt in possession.
- b. The warehouse operator shall mark the face of the warehouse receipt “canceled,” sign or initial and date it.
- c. The purchase of grain from a warehouse receipt shall be recorded on a document that is numbered at the time of printing and that contains the following information:
 - (1) Seller’s name;
 - (2) Warehouse receipt number;
 - (3) Number of bushels;
 - (4) Price;
 - (5) Items deducted from gross proceeds;
 - (6) Net value; and
 - (7) Check number, invoice reference, or credit-sale contract reference number.

One copy of the document shall be maintained by the licensee for inspection, and one copy shall be given to the seller.

90.13(4) *Surrender of warehouse receipts on cancellation, expiration, suspension or revocation of license.* When a warehouse operator license has expired or is canceled, suspended or revoked, all unused warehouse receipts under such license shall be surrendered to the bureau.

The bureau shall notify the warehouse operator that all outstanding warehouse receipts shall be returned to the bureau's office no later than 120 days from the date of cancellation, expiration, or revocation of the license.

90.13(5) *Purchase or return of grain, replacement receipt issued, or cancellation of outstanding receipts, upon cancellation, expiration, or revocation of warehouse operator license.* When a warehouse operator license has expired or is canceled or revoked, all stored grain shall be either purchased and payment made, or returned within 30 days to the holders of warehouse receipts or unpriced scale tickets, except when the warehouse is continuing operation under new ownership or when storage obligations are assumed by another licensee. Upon completion of delivery to the receipt holder or the reissuance of the receipt under a new license, the warehouse operator shall immediately mark "canceled," sign or initial and date such receipt on the face of the original copy, and forward such receipt to the bureau's office to be stamped with the department's cancellation stamp. When the storage obligations are assumed by a new licensee from a warehouse whose license is expired or has been canceled or revoked, replacement warehouse receipts shall be issued.

90.13(6) *Delivery conditioned upon return of outstanding warehouse receipt.* No product represented by an outstanding warehouse receipt shall be delivered until the original outstanding warehouse receipt is returned to the warehouse operator. The receipt shall be held by the warehouse operator as an open warehouse receipt until the delivery is completed. If periodic partial delivery is made against a nonnegotiable warehouse receipt, the delivery shall be documented on the back of the original warehouse receipt or other method of documentation approved by the bureau showing the net balance in store. Original nonnegotiable warehouse receipts may be maintained in alphabetical or numerical order. If partial delivery is made against a negotiable warehouse receipt, the warehouse receipt shall be canceled and a replacement warehouse receipt issued for the balance in store.

90.13(7) *Cancellation of warehouse receipt conditioned on removal from storage, purchase and payment, reissuance of receipt, or execution of a credit-sale contract.* No warehouse receipt shall be canceled by the warehouse operator unless:

- a. The product represented by the receipt has been removed from storage;
- b. The product has been purchased and payment made;
- c. A replacement receipt is issued at the time the receipt is canceled; or
- d. The product represented by the receipt is purchased and a credit-sale contract is properly executed.

This rule is intended to implement Iowa Code sections 203C.16, 203C.17, 203C.18, 203C.34 and 203C.35.

[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.14(203C) Lost or destroyed receipt. If a warehouse receipt is lost or destroyed, one of three methods shall be used in canceling the receipt. The following procedures shall be adhered to:

90.14(1) *Depositor's lost warehouse receipt release.* If the depositor or warehouse receipt holder has lost the receipt and is either selling all of the grain to the warehouse operator or removing all of the grain from storage, a Lost Warehouse Receipt Release shall be used. The release shall be completed in duplicate and signed by the receipt holder and shall be notarized. Both copies shall be retained in the warehouse records in lieu of the original copy of the receipt, which shall be given to the bureau at the time of an examination. One copy of the release shall be filed with the bureau at the time of an examination.

90.14(2) *Bond for issuance of duplicate receipts.* If the depositor has lost a warehouse receipt and needs a duplicate warehouse receipt, the depositor shall obtain a bond made in favor of the warehouse operator in accordance with the provisions of Iowa Code section 554.7601 (Uniform Commercial Code). This bond shall be in the amount of at least double the market value of the commodity at the time of posting the bond. A copy of the bond shall also be filed with the bureau. Upon issuance of a duplicate receipt, it shall be marked "Duplicate of lost warehouse receipt No. _____," in the space provided under

“Remarks,” and the lost warehouse receipt number shall be inserted in that space. The bond shall be in the warehouse operator’s possession prior to the issuance of a duplicate receipt.

90.14(3) Licensee’s lost warehouse receipt affidavit. If a warehouse receipt has been lost or destroyed by the warehouse operator, the warehouse operator shall prepare an affidavit in duplicate, signed before a notary public, stating that the warehouse receipt was lost or destroyed on or about (date). The affidavit shall also state that after a diligent search was made, the warehouse receipt cannot be found and that no obligation is due any person under that warehouse receipt. The affidavit shall further state that if the lost receipt is found, it shall be forwarded immediately to the bureau for cancellation. If a depositor’s name is on record under the warehouse receipt, the bureau may require that the warehouse operator also obtain a written statement from the depositor that confirms that the depositor has been paid for the grain or the depositor has received the grain back and that the depositor has no further claim against said receipt. The affidavits shall be held in lieu of the original copy of the warehouse receipt. The original copy shall be given to the bureau at the time of an examination.

This rule is intended to implement Iowa Code section 203C.19.
[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.15(203C) Warehouse receipts.

90.15(1) Warehouse receipt forms. Warehouse receipt forms shall be 8.25 inches wide by 7 inches long or 8.5 inches wide by 11 inches long and shall be printed in not less than triplicate. The original receipt shall be white, and the weight of the paper shall not be less than 20-pound base; the warehouse operator’s copy shall be yellow and the weight of the paper shall not be less than 16-pound base; and the owner’s copy shall be green and the weight of the paper shall not be less than 16-pound base. Receipts issued for bulk grain and receipts issued for agricultural products other than bulk grain shall be in a form prescribed by the department. The bureau shall have control over the printing of warehouse receipts.

90.15(2) Electronic warehouse receipts. A warehouse operator licensed in accordance with the provisions of Iowa Code chapter 203C may contract with an independent provider to issue electronic warehouse receipts for grain and other agricultural products subject to the provisions of this chapter. The provider shall be approved by the department.

90.15(3) Electronic warehouse receipt providers and provider agreements. A provider shall be independent of any outside influence or bias in action or appearance. A provider shall enter into a provider agreement with the department prior to being approved by the department. A provider shall file and maintain electronic warehouse receipts only on behalf of licensed warehouse operators who contract with the provider for those services. The provider agreement shall be subject to, but not be limited to, the provisions of paragraphs “a” through “k” of this subrule.

a. Provider to be approved by the USDA. No provider shall be approved by the department unless the provider is first approved as an electronic warehouse receipt provider by the USDA pursuant to the provisions of 7 CFR Part 735. Upon department request, a provider shall provide a copy of the provider’s executed USDA Form WA-460 and any addenda, and any other documentation requested by the department to confirm that the provider is a USDA-approved provider in good standing.

b. USDA action against providers. In the event that the USDA shall take action to deny, withdraw, suspend, reinstate or terminate a USDA Provider Agreement, the department shall automatically take the same action and the provider shall be subject to such action by the department. A provider shall notify the department of any such actions taken by the USDA.

c. Provider to service only licensed warehouse operators. A provider shall enter into user agreements under the terms of this rule only with warehouse operators licensed in accordance with the provisions of Iowa Code chapter 203C. A provider shall not issue electronic warehouse receipts for grain or other agricultural products on behalf of a warehouse operator in the state of Iowa unless the warehouse operator is licensed in accordance with the provisions of Iowa Code chapter 203C or the United States Warehouse Act.

d. Notice requirements for providers.

(1) When entering into a new user agreement, a provider shall provide written notice to the department.

(2) All notices to the USDA required by 7 CFR Part 735 and in the USDA Provider Agreement shall also be served upon the department except as specifically exempted in the provider agreement.

(3) In the user agreement, a provider shall include a notice to the warehouse operator that the data on the provider's central filing system is subject to disclosure to the department and the USDA.

e. Provisions to cease issuing electronic warehouse receipts. Upon notice by the department that a warehouse operator license issued under Iowa Code chapter 203C has expired or has been canceled, suspended or revoked, a provider shall prohibit the warehouse operator from issuing any electronic warehouse receipts until further notice from the department.

f. Department access to electronic warehouse receipt data. A provider shall allow the department unrestricted access to the central filing system for electronic warehouse receipts issued on behalf of warehouse operators licensed by the department. The electronic warehouse receipt data shall be maintained for six years after cancellation of the receipts. Access shall be made available in a manner that allows interaction with department warehouse examinations. Access shall be free of any charge or costs to the department.

g. Information profile. Upon issuance of a new user agreement to a warehouse operator licensed under Iowa Code chapter 203C, the provider shall notify the department and request an information profile. The department shall provide an information profile about the warehouse operator to the provider. The information profile shall consist of identifying information unique to each warehouse operator and shall be contained within each electronic warehouse receipt issued by a warehouse operator. The information profile shall include all statements and content required for warehouse receipts by the laws of the state of Iowa and as required by the provisions of the USDA Form WA-460 and any addenda pursuant to paragraph "a" of this subrule. This information profile shall include, but not be limited to, the following:

- (1) The warehouse operator's name;
- (2) The type of business organization and the state under whose laws the business is organized;
- (3) The location of the warehouse operator's corporate headquarters and the location of the warehouse;
- (4) The warehouse operator's license number; and
- (5) For grain warehouse receipts, the following statement: "The warehouse operator named herein, licensed under Iowa Code chapter 203C, has received for storage bulk grain of the amount, kind and grade, as determined in accordance with the official grain standards of the United States, for which this receipt is issued, subject to the provisions of Iowa Code chapters 203C and 203D and the applicable rules. Said grain is fully insured, unless otherwise allowed by law and noted within this receipt, by the above-named warehouse operator against loss or damage by fire, windstorm and inherent explosion."

h. Termination of provider agreement. The department or provider may terminate the provider agreement upon 60 days' written notice to the other party. The department shall terminate a provider agreement on less than 60 days' notice in accordance with paragraph "b" of this subrule. Upon termination of the provider agreement, the provider shall immediately surrender copies of the electronic data and paper records to the department for any electronic warehouse receipts contained within the central filing system. Such data and paper record copies, however, are limited to electronic warehouse receipts issued by warehouse operators licensed under the provisions of Iowa Code chapter 203C.

i. Authorization, jurisdiction and liability. A provider shall be authorized to transact business in the state of Iowa and shall consent to jurisdiction in the state of Iowa and venue in Polk County, Iowa. A provider shall be liable to the department for costs incurred by the department as a result of action taken in the event of a failure of the central filing system or any inability to provide the access required in paragraph "f" of this subrule.

j. Nonexclusive use. A warehouse operator shall not be required to issue warehouse receipts in electronic form.

k. Receiverships and indemnity fund claims—department as electronic warehouse receipt holder.

(1) A provider shall allow for the department and the grain indemnity fund board to be a sole or joint holder of an electronic warehouse receipt when the issuing warehouse operator's license has been revoked and either one or both of the following apply:

1. The electronic warehouse receipt has been surrendered to the department by a claimant for the proceeds of a grain receivership pursuant to Iowa Code chapter 203C.

2. The electronic warehouse receipt has been surrendered to the department or the grain indemnity fund board by a claimant for payment of a grain indemnity fund claim pursuant to Iowa Code chapter 203D.

(2) When an electronic receipt holder files a claim against a grain receivership or against the grain indemnity fund, the department shall obtain the consent and instruction of the holder to change the holder information on the provider's central filing system. The provider shall take any action ordered by the department in regard to an electronic warehouse receipt involved with a grain receivership or a grain indemnity fund claim. The department shall provide documentary evidence of the claim and any resulting required action to the provider. The department may order any action including, but not limited to, the following:

1. Reducing the quantity and value of the product represented by an electronic receipt upon payment of partial value from either receivership proceeds or the grain indemnity fund;

2. Prohibiting an electronic warehouse receipt from being negotiated or otherwise transferred without the department's consent due to payment of partial value from either receivership proceeds or the grain indemnity fund;

3. Canceling a warehouse receipt upon payment of full value to a claimant from receivership proceeds, and issuing a replacement receipt to the department if needed.

90.15(4) *Electronic warehouse receipt users and agreements.* Prior to engaging in the issuance of electronic warehouse receipts, a warehouse operator shall enter into a user agreement with a provider approved by the department. All electronic warehouse receipts issued by the warehouse operator shall be issued through and filed in the provider's electronic central filing system. As used in this subrule, "warehouse operator" means a warehouse operator who has obtained a license for the operation of a warehouse under Iowa Code section 203C.6. The use of electronic warehouse receipts is subject to the provisions of paragraphs 90.15(3)"a" through "g."

a. Warehouse operator to use only one provider. A warehouse operator shall issue electronic warehouse receipts through only one provider.

b. Changing providers. Subject to the provisions of a user agreement in effect, a warehouse operator may change providers once per year. The provider shall follow the transfer terms specified in USDA Form WA-460 and any addenda pursuant to paragraph 90.15(3)"a." The warehouse operator shall notify the department of a change in provider.

c. Numbering of receipts—no duplication. Electronic warehouse receipts shall be numbered and shall be issued consecutively starting with the number specified to the provider by the department. A warehouse operator shall not at any time have an electronic warehouse receipt and a paper warehouse receipt outstanding for the same lot of grain.

d. Nonexclusive use. A warehouse operator shall not require a depositor to accept an electronic warehouse receipt in lieu of a paper warehouse receipt.

e. Receipt holder power of attorney. A warehouse operator or a third party may not handle electronic warehouse receipts on behalf of a depositor unless a written power of attorney to do so has been provided by the depositor. Such power of attorney shall be provided to the department for inspection and verification upon the department's request.

f. Issuance and cancellation of receipts. The provisions for issuance and cancellation of warehouse receipts found in rules 21—90.12(203C) and 21—90.13(203C) shall apply to electronic warehouse receipts except to the extent that the rules are not applicable to electronic warehouse receipts. A warehouse operator shall not cancel an electronic warehouse receipt unless the warehouse operator is the holder of the warehouse receipt.

This rule is intended to implement Iowa Code sections 203C.2, 203C.5, 203C.6 and 203C.18.
[ARC 7553B, IAB 2/11/09, effective 3/18/09; ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.16(203C) Tariffs. Each warehouse operator, at the time of making application for a warehouse operator license, shall file a tariff with the bureau. The tariff shall be on a form prescribed by the bureau

and furnished to the applicant upon request. The tariff shall contain rates to be charged for storage, receiving, and loadout of stored products. After being properly numbered and dated by the bureau, the tariff shall be returned to the licensee for posting in a conspicuous location. A copy of the tariff shall be posted in each location where grain is weighed and delivered.

90.16(1) *Application of tariff.* The tariff rates applicable to stored products shall be those as contained in the tariff on file with the bureau at the time the product is received for storage. The tariff rates shall be applicable on an annual basis from date of deposit. If a tariff is amended, the charges shall be applied in accordance with subrule 90.16(3). Tariff charges shall cease upon cancellation, expiration, or revocation of a warehouse operator license. Tariff charges shall continue in accordance with the rates as filed by the successor warehouse operator. In the determination of the applicable rates to be applied under the successor warehouse operator's tariff, the date of deposit under the new tariff shall be the actual date of deposit. No charges shall apply to grain held for less than 30 days and for which no warehouse receipt has been issued unless the warehouse operator has a posted policy which provides for a shorter time period.

90.16(2) *Supplemental tariff.* The warehouse operator may file with the bureau a supplemental tariff that sets tariff rates for grain meeting special descriptive standards or characteristics. The supplemental tariff shall include the special descriptive standards or characteristics and the rates that will apply to grain meeting those standards or characteristics. The supplemental tariff shall be posted next to the regular warehouse tariff.

90.16(3) *Amending tariff.* The warehouse operator may amend a tariff by filing a new tariff with the bureau, including all supplemental tariffs. The amended tariff shall contain rates as specified by the warehouse operator. The previous tariff shall be posted and continue to apply on all products that are received prior to the effective date of the amended tariff until the anniversary date of deposit unless the new tariff is lower, in which case the amended tariff shall become effective immediately. The amended tariff shall apply to any products received after the effective date of the amendment. The amended tariff shall apply to any products stored under the previous tariff on the anniversary date of the storage period. The effective date of the amended tariff will be the date on which the tariff is received by the bureau or a specified later date.

90.16(4) *Documentation of tariff charges.* Documents on which storage is billed, including bushels and type of commodity, must contain a reference to each warehouse receipt or storage document.

This rule is intended to implement Iowa Code sections 203C.2, 203C.7, 203C.27 and 203C.28.
[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.17(203C) Records. A warehouse operator shall maintain complete and sufficient records to show all deposits, purchases, sales, storage obligations and loadouts of the warehouse.

90.17(1) *Maintaining warehouse receipts.* Unused warehouse receipts shall be maintained in numerical order. The warehouse operator's copy (yellow) of outstanding warehouse receipts and the original copy (white) of warehouse receipts canceled since the previous examination shall be maintained in separate numerical sequences.

90.17(2) *Daily position record.* The daily position record shall summarize one month's activity in a format approved by the bureau. The daily position record shall indicate at least the increases and decreases and ending balances on a daily basis for total stocks, open storage, warehouse-receipted, unpaid company-owned, and paid company-owned, and shall indicated the ending balance of total company-owned. The daily position record shall reflect the obligations in the appropriate columns. A separate daily position record shall be maintained:

- a. For each kind and class of grain; and
- b. For each type of commodity that is identity-preserved in licensed facilities.

All daily entries to the daily position record shall reflect transactions made through that day's close of business unless another time of day is elected by the licensee and applied by the licensee on a consistent basis.

90.17(3) *Scale tickets.* Unless the warehouse operator utilizes a computer system which sequentially numbers and prints scale weight tickets, every warehouse operator shall have prenumbered scale tickets.

Every scale ticket shall show, at a minimum, the following:

- a. The warehouse operator's name and location where the grain was delivered;
- b. Date;
- c. Depositor's name;
- d. Gross weight, tare weight, and delivered weight;
- e. Type of product or commodity; and
- f. An indication of whether product or commodity is being received or loaded out.

A copy of each ticket shall be maintained in numerical order by the warehouse operator as part of the records, unless the warehouse operator uses a computer system which sequentially numbers and prints scale tickets and the scale ticket information can be retrieved and reprinted by the computer system. Such systems must be approved in writing by the warehouse bureau. A scale ticket printed at the time of weighing shall be the document of record. All copies of reprinted scale tickets shall be marked "duplicate." All scale ticket forms in the possession of a warehouse operator shall have been permanently and consecutively numbered at the time of printing. The licensee shall be responsible for providing a list of all scale tickets used at each location.

90.17(4) Settlement sheets. Unless the warehouse operator utilizes a computer system which sequentially numbers and prints settlement sheets as generated, every warehouse operator shall have prenumbered settlement sheets. All settlement sheets shall show, at a minimum, the following:

- a. The warehouse operator's name and location;
- b. The seller's name and address;
- c. Date(s) of deliveries;
- d. Scale ticket numbers;
- e. Amount, kind and grade factors of the grain; and
- f. Method of settlement:
 - (1) If priced, the price per bushel, the quantity of grain priced and the date of pricing.
 - (2) If paid for, the date, price per bushel, the quantity of grain paid for, the amount of payment and check number or electronic funds transfer number.
 - (3) If credit-sale contract, the contract type, date and number and the quantity of grain transferred to the contract.
 - (4) If warehouse receipt, the receipt number, date of issuance and quantity of grain transferred to the receipt.
 - (5) If removed from the warehouse, the delivery document numbers, dates and amounts of the shipments.

Copies of all settlement sheets shall be maintained in numerical or alphabetical order by the warehouse operator as part of the records, unless the warehouse operator uses a computer system approved in writing by the bureau which sequentially numbers and prints settlement sheets and the settlement sheets can be retrieved on and reprinted by the computer system. A copy of the settlement sheet shall be given to the depositor upon demand, upon the issuance of a credit-sale contract, upon the issuance of a warehouse receipt or upon the completion of returning the commodity to the depositor. Any settlement sheet used in the pricing of grain for the purpose of sale to the warehouse operator shall have the price shown on all copies of such settlement sheet. Deliveries and settlement transactions shall be posted to the settlement sheet on a daily basis unless a computer system utilized can generate a scale ticket summary sheet for each depositor.

90.17(5) Multiple locations. If the licensee operates multiple locations under one license, the branch locations may maintain a separate series of the following documents:

- a. Scale tickets;
- b. Settlement sheets;
- c. Credit-sale contracts;
- d. Warehouse receipts; and
- e. Checks.

However, upon issuance, the warehouse operator's copy (yellow) of all warehouse receipts and a copy of each credit-sale contract shall be returned to the main location.

90.17(6) Inspection. For the purpose of inspection, the hours of 8 a.m. to 5 p.m., except Saturday, Sunday and holidays, shall be considered as ordinary business hours. All financial records, grain records and payment records shall be available for inspection by the bureau during ordinary business hours and any other time specified by the bureau in writing. All records shall be made available within the state of Iowa upon request.

90.17(7) Retention of records. All records shall be kept for a period of not less than six years. Such records shall be kept for the stated time period even if a license has expired or has been canceled or revoked.

90.17(8) Grade factors on scale tickets. All grade factors for determining the quality and grade of grain in accordance with the Official United States Standards for Grain shall be documented on scale tickets or supplemental records at time of deposit.

This rule is intended to implement Iowa Code sections 203C.2, 203C.17, and 203C.35.
[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.18(203C) Adjustment of records.

90.18(1) Adjustment of inventory for operational shrink. The department may require a licensee to take an operational shrink not to exceed one-half of one percent on grain received on a monthly basis.

90.18(2) Other inventory adjustments. Any reduction of record obligation shall be justified. Any increase in adjustments of record obligation shall be made only upon department approval or request. An upward adjustment may be made to the records at any time that a total weigh-up for a particular kind of grain is made and all records of the weigh-up have been maintained for verification. The licensee may make upward adjustments for rail and barge shipments based upon actual unloaded weights when the origin weights were estimated. Outbound truck shipments must be weighed on the licensee's scale if one is available. A warehouse operator may voluntarily adjust the records at the time of examination when the measured inventory exceeds the record obligation in an amount in excess of 1½ percent. All adjustments shall be readily identifiable in the daily position record. Unless the delivered weight is adjusted for and reflects dry bushels, all adjustments for moisture shall be shown in the records. A computer-generated scale ticket listing that shows gross weights and net weights will satisfy the requirements of this rule.

This rule is intended to implement Iowa Code section 203C.2.
[ARC 2035C, IAB 6/10/15, effective 7/15/15]

21—90.19(203C) Shrinkage due to moisture. A person who, in connection with the receipt of grain for storage, processing, or sale, adjusts the scale weight of the grain to compensate for the moisture content of the grain; or to compensate for losses to be incurred during the handling, processing, or storage of grain shall do so in accordance with provisions of Iowa Code section 203C.25.

This rule is intended to implement Iowa Code section 203C.25.

21—90.20(203C) Monthly grain statements. A grain statement shall be prepared at the close of business at the end of each calendar month and filed with the bureau by the tenth of the following month. This grain statement shall be on a form or in a format prescribed by the bureau. The bureau shall furnish forms to the warehouse operator upon request. A grain statement shall be filed for each calendar month regardless of whether or not the warehouse operator has products in storage.

This rule is intended to implement Iowa Code section 203C.2.
[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.21(203C) Grain stored in another warehouse. Upon approval by the bureau, a warehouse operator may store grain in another licensed warehouse in accordance with Iowa Code section 203C.39 as amended by 2012 Iowa Acts, Senate File 2311, section 116.

90.21(1) Decision criteria. The department shall consider the following in deciding to approve or deny a warehouse operator's request to store grain in another licensed warehouse:

a. The other licensed warehouse is located in Iowa and is either licensed by the department pursuant to Iowa Code chapter 203C or licensed pursuant to the United States Warehouse Act.

b. The other licensed warehouse is located in another state and is licensed pursuant to the United States Warehouse Act.

c. The other licensed warehouse is located in another state and is licensed pursuant to that state's statutes and that state's warehouse license provides all of the following:

- (1) Financial requirements and examination programs essentially equivalent to Iowa's;
- (2) Insurance coverage equivalent to Iowa's; and
- (3) Indemnification, surety bond coverage, letter of credit or other security satisfactory to the department.

90.21(2) Notice and licensing. Upon receipt of a written request from a warehouse operator to store a specified amount of grain in another warehouse and confirmation of compliance with Iowa Code section 203C.6, the bureau shall issue an amended license to the warehouse operator. The amended license shall show the number of bushels which the warehouse operator is authorized to store in another warehouse. The warehouse operator shall not store grain in another warehouse prior to the issuance of the amended warehouse operator license.

90.21(3) Net worth requirement. The number of bushels of grain to be stored in another warehouse shall be added to the warehouse operator's gross capacity. The warehouse operator must have sufficient net worth to cover the gross capacity or provide a deficiency bond or irrevocable letter of credit as provided for in Iowa Code section 203C.6. The net worth requirements of Iowa Code section 203C.6 shall not apply to transfers of grain between warehouses licensed by the same entity.

90.21(4) Trust warehouse receipts. A warehouse operator who stores grain in another warehouse shall obtain a nonnegotiable warehouse receipt for the grain stored. The receipt shall clearly show the following notation: "Held in Trust for the Depositors of (name of original receiving warehouse)". The warehouse receipt shall be on an official form as specified in 21—90.15(203C), an official United States Department of Agriculture authorized bonded warehouse receipt as provided for in the United States Warehouse Act or on an official form as specified in the regulations of the state in which the warehouse receipt is issued.

90.21(5) Record keeping—daily position record. Grain stored in another warehouse under the provisions of this rule shall be reflected in the total stocks section and the appropriate obligations section of the warehouse operator's daily position record.

90.21(6) Record keeping—shipment records. Grain shipped to another warehouse operator under the provisions of this rule shall be documented on scale tickets. The warehouse operator shall either clearly indicate "forwarded grain" on the scale ticket or maintain a supplementary record of such shipments. The warehouse operator shall at all times maintain a record of the amount of grain stored in another elevator.

90.21(7) Monthly grain statement requirement. On the monthly statements filed pursuant to rule 21—90.20(203C), a warehouse operator shall disclose the amount of each type of grain stored in another warehouse.

This rule is intended to implement Iowa Code sections 203C.2 and 203C.39.
[ARC 0392C, IAB 10/17/12, effective 11/21/12]

21—90.22(203C) Warehouse operator's obligation and storage. A warehouse operator shall at all times maintain sufficient quality and quantity of stored products in the warehouse to cover the obligations as examination of the records shall indicate. If, at the time of an examination, a shortage is determined, a warehouse operator shall purchase and make actual payment in the manner approved by the bureau for a sufficient quantity and quality of the commodity to fully cover the shortage by the end of the second business day after notice by the bureau, excluding weekends or holidays, unless the bureau chief receives within the same time period a confirmation from a surety company or financial institution for 100 percent bonding of the deficiency. Any shortage secured by 100 percent bonding within the allotted time period shall be covered in full within 30 days from the discovery of the shortage. A warehouse operator who does not have a sufficient quantity or quality of grain to satisfy the warehouse operator's obligation based on an examination by the department shall not purchase grain by credit-sale contract to correct the

shortage of grain. The department may suspend the license of any licensee who has a shortage and who is unable to satisfy the requirements of this rule.

This rule is intended to implement Iowa Code sections 203C.1 and 203C.17.

21—90.23(203C) Storing of products. Bulk grain in storage shall be stored in such a manner that the amount of grain in the storage facility can be readily determined. A product other than bulk grain shall be stored in such a manner that it can be readily inspected and the amount and kind thereof determined. The maintenance, conditioning, care, or surveillance shall be given to stored products as is required to maintain the quality, grade, and safe storage of the products. Nothing shall be placed or stored in a licensed facility that will in any way contaminate the stored products or cause any degrading of grade or value. Storage facilities shall not be overfilled. There shall be sufficient overhead airspace to provide adequate ventilation and to allow the examiner to readily determine the quality and quantity of the grain. The bureau chief may require the installation of overhead ventilation fans in facilities when in the bureau chief's judgment such fans are needed to preserve the quality of stored products. The bureau chief may require the installation of aeration equipment in storage facilities when it is deemed necessary to preserve the quality of stored products.

90.23(1) *Storage of contaminating products or more than one type of agricultural product.* Facilities may be licensed for both bulk grain and agricultural products other than bulk grain; however, if products of a contaminating nature are stored in the facility, the facility shall be removed from the license for any other agricultural products. If more than one type of an agricultural product is being stored in a facility, proper measures shall be implemented to keep such products from intermingling.

90.23(2) *Stored products in licensed facilities.* All stored products shall be maintained in licensed facilities.

This rule is intended to implement Iowa Code sections 203C.2, 203C.8 and 203C.16.
[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.24(203C) Facilities. No facility shall be considered suitable for the storage of bulk grain unless the warehouse has the necessary equipment such as grain leg, portable augers or vacuators for handling, receiving, and loading out of grain.

90.24(1) *No connection between facilities.* No unlicensed facility shall be connected to a licensed facility unless prior approval is obtained from the bureau.

90.24(2) *Scale required.* All licensees shall have an approved scale for inbound deliveries made by depositors.

This rule is intended to implement Iowa Code sections 203C.2 and 203C.8.

21—90.25(203C) Maintenance of storage facilities. All licensed storage facilities shall be maintained in such manner as to be suitable for the proper and safe storage of the particular product or products to be stored therein. Safe and adequate means of ingress and egress to the various storage units and grounds of the warehouse complex shall be provided and maintained by the warehouse operator. Sufficient louvers, outlets, overhead ventilation fans, aeration ducts and fans or any combination of these shall be maintained in each storage facility to prevent deterioration or spoilage and to maintain proper and safe storage of stored products.

90.25(1) *Inspection safety specifications for ladders and lifts on storage units.* Storage units having entrances over 20 feet to a maximum of 100 feet above floor level shall be equipped with a fixed ladder, an attached circular or spiral stairway, an alternating tower-type stairway or a safe and adequate lift. Storage units having entrances in excess of 100 feet above floor level shall be equipped with an adequate electric lift. Catwalks or walkways between storage units may be provided in lieu of ladders or lifts between facilities. Rungs on fixed ladders shall be spaced not to exceed 1-foot centers, and there shall be sufficient space between the ladder rung and face of the structure to permit a safe foothold. Any structure required to have a fixed ladder shall have an approved safety cage which shall commence not less than 7 feet or more than 8 feet from ground level. Landing platforms shall be provided for each 30 feet of fixed ladder or fraction thereof for ladders constructed after December 31, 2005. Landing

platforms shall be provided for each offset of fixed ladder sections regardless of the length of the ladder sections. Any facilities with a safety cable and belt hookup that were approved for licensing prior to September 1, 1992, shall continue to be approved provided they are maintained in a safe working order. Any facilities with a fixed ladder more than 20 feet in length, but not more than 24 feet in length, that were approved for licensing prior to December 31, 2005, shall continue to be approved provided they are maintained in a safe condition.

90.25(2) *Catwalks, walkways, landing platforms and stairs.* Catwalks, walkways and landing platforms shall be equipped with a top rail 42 inches from the floor and a middle rail. Catwalks, walkways and landing platforms constructed after September 1, 1992, must also be equipped with toeboards which are at least 4 inches in height and which are not more than ¼ inch from the floor. Stairways shall be equipped with handles which are not more than 34 inches nor less than 30 inches in height and of similar construction as catwalk or walkway rails. Catwalks, walkways, landing platforms, stairways, lifts and ladders shall be kept clean and free of grain and other matter which might endanger the safety of persons using them. Guardrails shall be placed around the entrance to any storage facility exceeding 30 feet above the floor, or around a landing platform below such entrance to a facility. At no time shall electrical lines be anchored on or within reach of a ladder or safety cage unless enclosed in conduit. All electrical lines in proximity of the inspection ladder, stairway, walkway or lift shall be enclosed in conduit.

90.25(3) *Removal of facilities from warehouse operator license.* Any storage facility which fails to meet the requirements of this rule shall be called to the attention of the warehouse operator. Failure of the warehouse operator to place the facility in a suitable condition within a reasonable length of time shall result in the elimination of the facility from coverage under the warehouse operator license in accordance with the provisions of Iowa Code section 203C.8. However, if in the bureau's judgment any facility is unsafe to gain ingress and egress at the time of an examination, the products stored in the facility may not be included in the inventory. Any facility which has deteriorated to the extent that it is unsuitable for storage shall be immediately removed from the warehouse operator license in accordance with the provisions of Iowa Code section 203C.8, until such time that the facility meets the requirements of this rule and has been reinspected.

This rule is intended to implement Iowa Code sections 203C.2 and 203C.8.

21—90.26(203C) Temporary grain storage facilities. A temporary grain storage facility may, in the discretion of the department, be approved and licensed on the following bases:

90.26(1) *License period.* A license for a temporary storage facility may be issued at any time but shall be effective for the storage of grain only from August 1 to May 1 of the following year. A temporary storage facility license shall expire each May 1 unless the licensee requests and obtains an extension in accordance with subrule 90.26(2).

90.26(2) *Extensions.* An extension of 90 days may be granted if all of the following requirements are satisfied:

a. The licensee has requested an original extension or an additional extension no later than 45 days prior to the expiration of the licensing period or extension then in effect.

b. The bureau has completed an examination of the licensee's temporary storage facility.

c. The licensee has paid the bureau for the cost of the examination of its temporary storage facility. The payment shall include the labor cost, the equipment cost, the sampling cost and any additional costs incurred by the bureau in examining a licensee's temporary storage facilities. Payment shall be made and received by the bureau before any extension may be granted.

d. Every temporary storage facility for which the department has granted an extension shall continue to meet all of the other requirements of rule 90.26(203C). Before an extension is granted, the bureau chief may require the filing of a bond or irrevocable letter of credit in an amount to be determined by the department.

90.26(3) *Restrictions on extensions.* The licensing period for a temporary storage facility may be extended beyond August 1. However, the extension of a licensing period for a temporary storage facility shall not result in the granting of a new August 1 to May 1 licensing period. As a result, a licensee shall

be required to request additional extensions at least 45 days prior to the expiration of the extension then in effect.

90.26(4) Expiration. The warehouse operator shall either purchase the grain stored in the temporary storage facility or remove the grain from the temporary storage facility prior to May 1 or prior to the expiration of a granted extension.

90.26(5) Specifications for temporary storage facilities. Every temporary storage facility shall comply with the following specifications:

a. Each storage unit shall contain aeration equipment to provide at least .13 cubic feet of air per bushel per minute.

b. Each storage unit shall have an asphalt base, concrete base, pozzuolanic base, or a compacted limestone base which meets the following minimum specifications:

(1) Base shall be of a depth and compaction to permit trucks or other equipment, used in loading or unloading the pad, to move around over the base without breaking through or unduly scuffing the surface.

(2) Depth of limestone top shall not be less than four inches.

(3) Adequate slope and drainage away from the base shall be provided to prevent any water from standing or backing up under the grain. Base shall be at least six inches above surrounding area.

c. The angle of repose of the stored grain shall be maintained to provide sufficient drainage.

d. The storage unit shall be covered. The cover shall be of sufficient strength to resist tearing under normal expected conditions and to allow a person to walk on the cover without penetrating it.

e. All storage units shall have rigid sidewalls.

90.26(6) Inspection for licensing. Every temporary storage facility to be included under a warehouse operator license shall be inspected and licensed before any products to be stored are placed in the facility.

90.26(7) Limitation. Temporary licensed storage capacity may not exceed 50 percent of permanent licensed storage capacity. However, the department may issue a license for temporary storage capacity exceeding the temporary capacity limit of 50 percent for a licensing period ending on or before May 1.

90.26(8) Removal from license. The bureau chief or examiner shall issue written notice to the warehouse operator for any temporary storage facility which no longer meets the requirements of this rule. Failure of the warehouse operator to place the facility in a suitable condition within a reasonable length of time shall result in the elimination of the facility from coverage under the warehouse operator license. Any facility which has deteriorated to the extent that it is unsuitable for storage shall be immediately removed from the warehouse operator license until the time that the facility meets the requirements of this rule and has been reinspected.

90.26(9) Moisture and quality. Corn containing more than 14 percent moisture or soybeans containing more than 13 percent moisture shall not be stored in temporary facilities. Corn and soybeans which do not grade No. 2 or better using the Official United States Standards for Grain shall not be stored in a temporary storage facility.

90.26(10) Periodic maintenance. The warehouse operator will make observations of grain temperature, aeration outlet temperature and odor, condition of the cover and drainage as necessary to ensure the safe storage of the grain in a temporary storage facility. These observations shall be made at regular intervals.

This rule is intended to implement Iowa Code sections 203C.2, 203C.7, 203C.8, 203C.12, 203C.16, and 203C.18.

[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.27(203C) Emergency ground pile storage space. Emergency ground pile storage space may, in the discretion of the department, be approved and licensed for the storage of corn on the following bases:

90.27(1) License period. A license for emergency ground pile storage space shall be effective from August 1 to January 31 of the following year.

90.27(2) Expiration. The warehouse operator shall either purchase the grain stored in the emergency ground pile storage space or remove the corn from the emergency ground pile storage space prior to

February 1. Any corn remaining in such space after this date will not be included in grain inventory measurements made by the department, and such corn may not be used to cover storage obligations.

90.27(3) Bonding. Before any corn can be placed in licensed emergency ground pile storage space, the department shall receive either an irrevocable letter of credit or a surety bond in the amount of \$2 for each bushel to be placed in emergency ground pile storage space. The irrevocable letter of credit or surety bond will expire on April 1. The issuer shall not cancel the irrevocable letter of credit or surety bond filed with the department under this rule on less than 45 days' notice by certified mail to the department and to the licensee. When the department receives notice from an issuer that the issuer has canceled the irrevocable letter of credit or surety bond, and the letter of credit or surety bond is still needed, the department shall automatically suspend the license if the department does not receive a replacement irrevocable letter of credit or surety bond within 30 days of the issuance of the notice of cancellation. If a replacement irrevocable letter of credit or surety bond is not filed within 10 days following the suspension, the department shall automatically revoke the warehouse operator's license.

90.27(4) Specifications for emergency ground pile storage. All emergency ground pile storage space shall have an asphalt base, concrete base, or a compacted limestone base which meets the following minimum specifications:

- a. Base shall be of a depth and compaction to permit trucks or other equipment used in loading or unloading the pad to move around over the base without breaking through or unduly scuffing the surface.
- b. Depth of limestone top shall be not less than four inches.
- c. Adequate slope and drainage away from the base shall be provided to prevent any water from standing or backing up under the grain.

90.27(5) Licensing. All emergency ground pile storage space to be included under a warehouse operator license shall be licensed before any corn to be stored is placed in it.

90.27(6) Limitation. Emergency licensed ground pile storage space may not exceed 30 percent of permanent licensed storage capacity.

90.27(7) Record keeping. A separate daily position record shall be maintained on all corn placed in the emergency licensed ground pile storage space.

90.27(8) Moisture and quality. Corn containing more than 15 percent moisture shall not be stored in emergency ground pile storage space. Corn which does not grade No. 2 or better using the Official United States Standards for Grain shall not be stored in emergency ground pile storage space.

90.27(9) Removal from license. The bureau chief or examiner shall issue written notice to the warehouse operator for any emergency ground pile storage space which no longer meets the requirements of this rule. Failure of the warehouse operator to place the emergency ground pile storage space in a suitable condition within a reasonable length of time shall result in the elimination of emergency ground pile storage space from coverage under the warehouse operator license.

This rule is intended to implement Iowa Code sections 203C.2, 203C.7, 203C.8, 203C.12, 203C.16, and 203C.18.

21—90.28(203C) Polyethylene (polyvinyl) bag storage space. Polyvinyl bag storage space may, in the discretion of the department, be approved and licensed for the storage of corn on the following bases:

90.28(1) License period. A license for polyvinyl bag storage space shall be effective from August 1 to May 1 of the following year. A polyvinyl bag storage space license shall expire each May 1 unless the licensee requests and obtains an extension in accordance with subrule 90.28(2).

90.28(2) Extensions. An extension of 90 days may be granted if all of the following requirements are satisfied:

- a. The licensee has requested an original extension or an additional extension no later than 45 days prior to the expiration of the licensing period or extension then in effect.
- b. The bureau has completed an examination of the licensee's polyvinyl bag storage space.
- c. The licensee has paid the bureau for the cost of the examination of the licensee's polyvinyl bag storage space. The payment shall include the equipment cost, sampling cost, labor cost and any additional costs incurred by the bureau in examining a licensee's polyvinyl bag storage space. Payment shall be made and received by the bureau before any extension may be granted.

90.28(3) Restrictions on extensions. The licensing period for polyvinyl bag storage space may be extended beyond August 1. However, the extension of a licensing period for polyvinyl bag storage space shall not result in the granting of a new August 1 to May 1 licensing period. As a result, a licensee shall be required to request additional extensions at least 45 days prior to the expiration of the extension then in effect.

90.28(4) Expiration. The warehouse operator shall either purchase the corn stored in the polyvinyl bag storage space or remove the corn from the polyvinyl bag storage space prior to May 1 or prior to the expiration of a granted extension.

90.28(5) Specifications for polyvinyl bag storage space. All polyvinyl bag storage space shall comply with the following specifications:

- a. The polyvinyl bag shall be a minimum of 8.5 mil or thicker.
- b. The polyvinyl bag shall be white.
- c. The polyvinyl bag site shall be firm and free of objects that could puncture the polyvinyl bag. A gravel base will not be an approved surface.
- d. The following are approved surfaces:
 - (1) Asphalt base.
 - (2) Concrete base.
 - (3) Compacted limestone base.
 - (4) On turf or hay ground that has been mowed to a height (not more than 2.5 inches) not to puncture the polyvinyl bag.
 - (5) Bladed dirt.
- e. Adequate drainage away from the base shall be provided to prevent any water from standing or backing up under the polyvinyl bags.
- f. The polyvinyl bag site shall be free of any spilled grain and tall grass.
- g. The polyvinyl bag must be closed in accordance with the manufacturer's written instructions or so that no deterioration of the stored corn can occur.

90.28(6) Inspection for licensing. Polyvinyl bag storage space to be included under a warehouse operator license shall be inspected and licensed before any corn to be stored is placed into the bags.

90.28(7) Limitations. Polyvinyl bag storage space may not exceed 30 percent of permanent licensed storage capacity.

90.28(8) Moisture and quality. Corn containing more than 14 percent moisture shall not be stored in polyvinyl bags. Corn which does not grade No. 2 or better using the Official United States Standards for Grain shall not be stored in polyvinyl bags.

90.28(9) Removal from license. The bureau chief or examiner shall issue written notice to the warehouse operator for any polyvinyl bag which no longer meets the requirements of this rule. Failure of the warehouse operator to place the polyvinyl bag in a suitable condition within a reasonable length of time shall result in the elimination of the polyvinyl bag from coverage from the warehouse operator license. Any polyvinyl bag which has deteriorated to the extent that it is unsuitable for storage shall be immediately removed from the warehouse operator license until the time that the facility meets the requirements of this rule and has been reinspected.

90.28(10) Periodic maintenance. The warehouse operator will make such observations of the condition of the polyvinyl bags and the surface temperature of the corn as necessary to ensure the safe storage of the corn in polyvinyl bags. Such observations shall be made at regular intervals.

This rule is intended to implement Iowa Code sections 203C.2, 203C.7, 203C.8, 203C.12, 203C.16, and 203C.18.

[ARC 9388B, IAB 2/23/11, effective 3/30/11]

21—90.29(203C) Prioritization of inspections of warehouse operators. Warehouse operators with a probability of failure factor greater than 40 percent, as calculated by the statistical model, shall be examined at least twice in a 12-month period.

This rule is intended to implement Iowa Code sections 203C.2 and 203C.40.

21—90.30(203C) Department of agriculture and land stewardship enforcement procedures. The bureau shall follow a step-by-step enforcement policy to ensure consistent compliance with and application of this chapter. The department recognizes that violations of certain rules may have more serious ramifications; thus, the enforcement of those rules requires stricter policies. The enforcement policies apply to any violation of this chapter unless enforcement provisions are specifically addressed in a particular rule or subrule.

90.30(1) If it is necessary to establish proof of a violation of statute or rule, the bureau shall conduct a special investigation of the licensee. The bureau may contact the warehouse operator, the warehouse operator's employees, or any other interested party to gain information for its investigation. The bureau, in its investigation of a licensee, may cause a special examination to occur if evidence of at least one of the following conditions is present:

- a. Insufficient funds check or failed electronic funds transfer.
- b. Stalled payment for grain.
- c. Quantity deficiency.
- d. Quality deficiency.
- e. Incomplete or inaccurate records as specified in rule 21—90.17(203C).

The expense of such special examination shall be based on actual costs incurred by the bureau and may be assessed to the licensee. The costs shall include the labor, equipment, sampling and any additional costs incurred by the bureau. Payment shall be made as directed by the bureau.

90.30(2) Upon establishment of a rule violation by an examiner or the bureau, the bureau shall consider the following elements in determining the proper period of time within which to require a licensee to comply with the rules:

- a. Gravity of the offense.
- b. Likelihood of depositor loss.
- c. Length of time within which a reasonable licensee in a similar circumstance should be able to comply with the rule.

90.30(3) The bureau chief may initiate license suspension or revocation proceedings against the licensee for any violation of these rules. The bureau chief shall consider the following factors in making the determination to initiate the suspension or revocation proceedings:

- a. Likelihood of depositor loss.
- b. Gravity of the offense.
- c. Licensee's intent to violate the rule.
- d. Licensee's record of violations of statute or rule.
- e. Number of violations in the particular report.

90.30(4) The bureau chief may cause charges to be filed against the licensee for any violation of these rules. The bureau chief shall consider the following factors in making the determination to file charges:

- a. Likelihood of depositor loss.
- b. Gravity of the offense.
- c. Licensee's intent to violate the rule.
- d. Licensee's record of rule violations.
- e. Number of violations in the particular report.

90.30(5) The bureau chief may initiate the assessment of civil penalties against the licensee for any violation of these rules. The bureau chief shall consider the following factors in making the determination to initiate the assessment of civil penalties:

- a. Likelihood of depositor loss.
- b. Gravity of the offense.
- c. Licensee's intent to violate the rule.
- d. Licensee's record of violations of statute or rule.
- e. Number of violations in the particular report.

This rule is intended to implement Iowa Code sections 203C.2, 203C.10, 203C.36 and 203C.36A.

21—90.31(203C) Review proceedings. A warehouse operator or applicant may file a formal written complaint with the department if the warehouse operator or applicant contests any finding or decision of the bureau chief. Any such complaints shall be resolved in contested case proceedings conducted pursuant to the applicable provisions of 21—Chapter 2.

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¹ Applicable to Commerce Commission [250] Ch 12

ENGINEERING AND LAND SURVEYING EXAMINING BOARD[193C]

[Prior to 6/1/88, see Engineering and Land Surveying Examiners, Board of [390]]
[Engineering and Land Surveying Examining Board[193C] created by 1986 Iowa Acts, Ch 1245, §716,
within the Professional Licensing and Regulation Division[193] of the Commerce Department[181] “umbrella”]

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[Prior to 11/14/01, see 193C—Chapter 3]

193C—7.1(542B,272C) General statement. Each licensee is required to meet the continuing education requirements of this chapter for professional development as a condition of licensure renewal.

193C—7.2(542B,272C) Definitions. As used in these rules, the following definitions apply:

“*College or unit semester or quarter hour*” means the unit of credit given for advanced technical and graduate courses from universities with programs accredited by the Engineering Accreditation Commission of the Accreditation Board for Engineering and Technology, Inc. or other related college course qualified in accordance with this chapter.

“*Continuing education*” means education obtained by a licensee in order to maintain, improve, or expand skills and knowledge obtained prior to initial licensure or to develop new and relevant skills and knowledge.

“*Continuing education unit (CEU)*” means the unit of credit customarily granted for continuing education courses. One continuing education unit is given for ten hours of class in an approved continuing education course.

“*Course or activity*” means any qualifying course or activity with a clear purpose and objective which will maintain, improve, or expand the skills and knowledge relevant to the licensee’s field of practice.

“*Independent study*” means any course or activity in which there is no real-time interaction between the training provider and the licensee, such as courses offered on the Internet.

“*Professional development hour (PDH)*” means a contact hour of instruction or presentation and is the common denominator for other units of credit.

193C—7.3(542B,272C) Professional development hours.

7.3(1) Allowable activities. Licensees may earn professional development hours by participating in a variety of activities. The following is a sample list of allowable activities and is not all-inclusive:

- a. Successful completion of college courses;
- b. Successful completion of continuing education courses;
- c. Successful completion of correspondence, televised, videotaped, and other short courses or tutorials;
- d. Successful completion of courses on-line via the Internet;
- e. Active participation in seminars, in-house courses, workshops, technical committees of professional engineering organizations, and professional conventions;
- f. Teaching or instructing in the activities set forth above if such teaching or instruction is outside of the licensee’s regular employment duties and if the licensee can document such teaching activity or instruction was newly developed and presented for the first time;
- g. Authoring published papers, articles or books;
- h. Obtaining patents;
- i. Attendance at satellite down-link video courses;
- j. Participation on an NCEES examination development committee;
- k. Attendance at engineering college graduate research seminars.

All of the allowable activities listed above must meet the requirements and restrictions set forth in this chapter to be accepted by the board.

7.3(2) PDH conversion. The following chart illustrates the conversion from other units to PDH:

ACTIVITY	PDH
1 College or unit semester hour Credit for qualifying college or community college courses will be based upon course credit established by the college.	45 PDH per semester hour
1 College or unit quarter hour Credit for qualifying college or community college courses will be based upon course credit established by the college.	30 PDH per quarter hour
1 Continuing Education Unit as defined in 193C—7.2(542B,272C)	10 PDH
1 Contact hour attendance in a class, course, seminar, or professional or technical presentation made at a meeting, in-house training session, convention or conference. Credit for qualifying seminars and workshops will be based on 1 PDH unit for each hour of attendance. Attendance at qualifying programs presented at professional or technical society meetings will earn PDH units for the actual time of each program, excluding time for breaks and meals.	1 PDH per hour
1 Contact hour teaching a class, course, seminar, or a professional or technical presentation a. Teaching credit is valid for teaching a course or seminar for the first time only. b. Teaching credit does not apply to full-time faculty. c. Teaching credit is limited to 10 PDH per biennial renewal period.	2 PDH per hour
Each published paper, article, or book Credit for published material is earned in the biennium of publication.	10 PDH per publication
Active participation in a professional or technical society. Credit for active participation in professional and technical societies is limited to 2 PDH per renewal period per organization and requires that a licensee serve as an officer or actively participate in a committee of the organization. PDH credits are earned for a minimum of one year's service.	2 PDH per organization per renewal period
Each patent Credit for patents is earned in the biennium the patent is issued.	10 PDH per patent
Participation on an NCEES examination development committee or Iowa state specific land surveying examination development committee, including the writing and grading of examination questions, writing reference materials for examinations, and evaluating past examination question performance. Licensees may claim a maximum of 30 PDH per biennial renewal period for participation in this activity.	2 PDH per hour of committee participation

7.3(3) Determination of credit. The board has final authority with respect to approval of courses, credit, PDH value for courses, and other methods of earning credit. No preapproval of offerings will be issued. The board may deny any renewal or reinstatement upon a determination of insufficient or unsatisfactory continuing education.

[ARC 2022C, IAB 6/10/15, effective 7/15/15]

193C—7.4(542B,272C) Professional development guidelines. Continuing education activities that satisfy the professional development criteria are those that relate to engineering or land surveying practice or management. It is recognized that an engineer's specialized skills must have as their foundation a fundamental knowledge of chemistry, physics, mathematics, graphics, computations, communication, and humanities and social sciences. However, continuing education in the fundamentals alone will not be sufficient to maintain, improve, or expand engineering skills and knowledge. For that reason, licensees will be limited in their use of fundamental courses in proportion to ABET criteria for accreditation of engineering curricula. Continuing education activities are classified as:

7.4(1) Group 1 activities. Group 1 activities are intended to maintain, improve, or expand skills and knowledge obtained prior to initial licensure. The following chart illustrates the maximum PDH allowable per renewal period for Group 1 activities:

Type of course/activity	Number of PDH allowed per renewal period
Mathematics and basic sciences Math beyond Trigonometry Basic sciences: Chemistry, Physics, Life sciences, Earth sciences	10 PDH
Engineering sciences Mechanics, Thermodynamics, Electrical and electrical circuits, Materials science, *Computer science *Courses in computer science will generally be considered a part of the Engineering Sciences category in the ABET criterion and, therefore, limited to a maximum of 10 PDH per renewal period.	10 PDH
Humanities and social sciences Philosophy, Religion, History, Literature, Fine arts, Sociology, Psychology, Political science, Anthropology, Economics, Foreign languages, Professional ethics, Social responsibility	5 PDH
Engineering curriculum courses Accounting, Industrial management, Finance, Personnel administration, Engineering economy, English, Speech, *Computer applications *Courses in CAD and fundamental computer applications will generally not be applicable in either Group 1 or Group 2 activities. The computer is viewed as a tool available to the engineer or land surveyor, much as a pencil or hand-held calculator is a tool. Only computer courses that have the solution of engineering or land surveying problems as a purpose will be considered acceptable. An example of this might be a course that trains an engineer in the utilization of a specific software package to perform structural analysis. The concept of the computer as a tool does not apply to a computer engineer.	10 PDH

7.4(2) Group 2 activities. Group 2 activities are intended to develop new and relevant skills and knowledge. Credit for participation in activities in the group is unlimited, subject to maximum carryover. Typical areas include postgraduate level engineering science or design, new technology, environmental regulation and courses in management of engineering or land surveying activity (regular work duties do not qualify).

7.4(3) Independent study. To be readily acceptable by the board, independent study as defined in rule 193C—7.2(542B,272C) must meet all of the following criteria:

- a. A written evaluation process is completed by the independent study provider; and
- b. A certificate of satisfactory completion is issued by the provider; and
- c. An evaluation assessment is issued to the licensee by the provider; and
- d. Documentation supporting such independent studies is maintained by the licensee and provided to the board as required by subrule 7.8(2).

A maximum of ten professional development hours of independent study activity will be allowed per biennium per licensee.

7.4(4) Exclusions. Types of continuing education activities which will be excluded from allowable continuing education are those in which it is not evident that the activity relates directly to the licensee's practice of professional engineering or land surveying or the management of the business concerns of the licensee's practice, or which do not comply with the board's administrative rules. Examples of activities that do not qualify as continuing education include the following:

- Regular employment;
- Toastmasters club meetings;
- Service club meetings or activities;
- Personal estate planning;
- Banquet speeches unrelated to engineering;
- Professional society business meeting portions of technical seminars;
- Financial planning/investment seminars;
- Foreign travel not related to engineering study abroad;
- Personal self-improvement courses;
- Real estate licensing courses;
- Stress management;

- Trade shows;
- Peer review;
- Accreditation review;
- Independent study or self-study that does not meet the requirements of subrule 7.4(3);
- Basic CAD and fundamental computer application courses;
- Undergraduate engineering seminars.

193C—7.5(542B,272C) Biennial requirement. The biennial requirement must be satisfied during the biennium prior to licensure renewal except for the carryover permitted.

7.5(1) The continuing education requirement for biennial licensure renewal is 30 professional development hours for an active licensee in engineering or land surveying. The number of professional development hours that may be carried forward into the next biennium shall not exceed 15.

7.5(2) Inactive licensees are exempt from the continuing education requirements.

7.5(3) Continuing education requirements for licensure in more than one engineering branch are the same as for licensure in a single branch of engineering.

7.5(4) The continuing education requirement for biennial licensure renewal for an individual who is active in both engineering and land surveying is 20 professional development hours in engineering and 20 professional development hours in land surveying. The number of professional development hours that may be carried forward into the next biennium shall not exceed 10 hours for each profession.

7.5(5) A licensee who is active in one profession and inactive in another shall meet the continuing education requirements for licensure in the profession in which active licensure is maintained.

7.5(6) A new licensee shall satisfy one-half the biennial continuing education requirement at the first renewal following initial licensure.

193C—7.6(542B,272C) Exemptions. The continuing education requirements may be reduced in proportion to the following:

1. Periods of time that the licensee serves honorably on active duty in the military services;
2. Periods of time that the licensee is licensed in and a resident of another state or district having continuing education requirements for professional engineering or land surveying and meets all requirements of that state or district for practice therein;
3. Periods of time that the licensee is a government employee working as a professional engineer or professional land surveyor and assigned to duty outside the United States; or
4. Documented periods of the licensee's active practice and absence from the United States that are approved by the board.

No exemption will be granted without a written request from the licensee with documentation of the period of absence.

[ARC 0362C, IAB 10/3/12, effective 11/7/12]

193C—7.7(542B,272C) Hardships or extenuating circumstances. The board may, in individual cases involving hardship or extenuating circumstances, grant waivers of the continuing education requirements for a period of time not to exceed one year. No waiver or extension of time shall be granted unless the licensee makes a written request to the board for such action.

193C—7.8(542B,272C) Reports, records, and compliance review. At the time of application for license renewal, each licensee shall report, on a form provided by the board, the number of professional development hours achieved during the preceding biennium.

7.8(1) Record keeping. Maintaining records to be used to support professional development hours claimed is the responsibility of the licensee. It is recommended that each licensee keep a log showing the type of activity claimed, sponsoring organization, location, duration, instructor's or speaker's name, and PDH credits earned.

7.8(2) Compliance review. The board may select licensees for review of compliance with continuing education requirements on a random basis or upon receiving information regarding noncompliance and shall review compliance with continuing education requirements for reinstatement of lapsed or inactive

licenses. For each professional development hour claimed, licensees chosen for compliance review shall furnish:

- a. Proof of attendance. Attendance verification records in the form of completion certificates, or other documents supporting evidence of attendance;
- b. Verification of the hours claimed; and
- c. Information about the course content.

7.8(3) Compliance review sanctions. Any discrepancy between the number of PDHs reported and the number of PDHs actually supported by documentation may result in a disciplinary review.

7.8(4) Out-of-state residents. A person licensed to practice engineering or land surveying or both in Iowa shall be deemed to have complied with the continuing education requirement of this state during the periods that the person is a resident of another state or district which has a continuing education requirement for engineers or land surveyors and the individual meets all requirements of that state or district for practice therein. However, if selected for compliance review, such individuals must provide documentation as specified in 7.8(2).

These rules are intended to implement Iowa Code sections 272C.2, 272C.3, 542B.6, and 542B.18.

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CHAPTER 9
COMPLAINTS, INVESTIGATIONS AND DISCIPLINARY ACTION

[Prior to 11/14/01, see 193C—Chapter 4]

193C—9.1(542B) Complaints and investigations.

9.1(1) *Complaints.* The board shall, upon receipt of a complaint in writing, or may upon its own motion pursuant to other evidence received by the board, review and investigate alleged acts or omissions which reasonably constitute cause under applicable law or administrative rule for licensee discipline. Written complaints may be submitted to the board office by mail, E-mail, facsimile, or personal delivery by members of the public, including clients, business organizations, nonprofit organizations, governmental bodies, licensees, or other individuals or entities with knowledge of possible violations of laws or rules by licensees.

9.1(2) *Form and content.* A written complaint may be submitted on forms available from the board office and on the board's Web site. The written complaint shall include the following information:

- a.* The full name, address, and telephone number of complainant (individual who is complaining).
- b.* The full name, address, and telephone number of respondent (individual against whom the complaint is filed).
- c.* A statement of the facts and circumstances giving rise to the complaint, including a description of the alleged acts or omissions which the complainant believes demonstrate that the respondent has violated or is violating laws or rules enforced by the board.
- d.* Citation of the statutes and administrative rules allegedly violated by the respondent.
- e.* Evidentiary supporting documentation.
- f.* Steps, if any, that have been taken by the complainant to resolve the dispute with the respondent prior to the filing of the complaint.

9.1(3) *Initial complaint screening.* All written complaints received by the board shall be initially screened by the board's administrator to determine whether the allegations of the complaint fall within the board's investigatory jurisdiction and whether the facts presented, if true, would constitute a basis for disciplinary action against a licensee. Complaints which are clearly outside the board's jurisdiction, which clearly do not allege facts upon which disciplinary action would be based, or which are frivolous shall be referred by the board administrator to the board for closure at the next scheduled board meeting. All other complaints shall be referred by the board administrator to the board's disciplinary committee for committee review.

9.1(4) *Investigation of allegations.* In order to determine if probable cause exists for a hearing on the complaint, the board may cause an investigation to be made into the allegations of the complaint. It may refer the complaint to a peer review committee or investigator for investigation, review and report to the board.

9.1(5) *Informal discussion.* If the board considers it advisable, or if requested by the affected licensee, the board may grant the licensee an opportunity to appear before the board or a committee of the board for a voluntary informal discussion of the facts and circumstances of an alleged violation. The licensee may be represented by legal counsel at the informal discussion. The licensee is not required to attend the informal discussion. By electing to attend, the licensee waives the right to seek disqualification, based upon personal investigation of a board member or staff, from participating in making a contested case decision or acting as a presiding officer in a later contested case proceeding. Because an informal discussion constitutes a part of the board's investigation of a pending disciplinary case, the facts discussed at the informal discussion may be considered by the board in the event the matter proceeds to a contested case hearing and those facts are independently introduced into evidence. The board may seek a consent order at the time of the informal discussion. If the parties agree to a consent order, a statement of charges shall be filed simultaneously with the consent order.

9.1(6) *Immunity.* As provided by Iowa Code section 272C.8, a person shall not be civilly liable as a result of filing a report or complaint with the board unless such act is done with malice, nor shall an employee be dismissed from employment or discriminated against by an employer for filing such a report or complaint.

9.1(7) *Role of complainant.* The role of the complainant in the disciplinary process is limited to providing the board with factual information relative to the complaint. A complainant is not party to any disciplinary proceeding which the board may initiate based in whole or in part on information provided by the complainant.

9.1(8) *Role of the board.* The board does not act as an arbiter of disputes between private parties, nor does the board initiate disciplinary proceedings to advance the private interest of any person or party. The role of the board in the disciplinary process is to protect the public by investigating complaints and initiating disciplinary proceedings in appropriate cases. The board possesses sole decision-making authority throughout the disciplinary process, including the authority to determine whether a case will be investigated, the manner of the investigation, whether a disciplinary proceeding will be initiated, and the appropriate licensee discipline to be imposed, if any.

193C—9.2(542B) Ruling on the initial inquiry.

9.2(1) *Dismissal.* If a determination is made by the board that a complaint is without grounds or merit, the complaint shall be dismissed. A letter of explanation concerning the decision of the board shall be sent to the respondent and the complainant.

9.2(2) *Requirement of further inquiry.* If determination is made by the board to order further inquiry, the complaint and initial recommendations shall be provided to the investigator(s) along with a statement specifying the information deemed necessary.

9.2(3) *Acceptance of the case.* If a determination is made by the board to initiate disciplinary action the board may enter into an informal settlement or recommend formal disciplinary proceedings. The board's rules regarding informal settlement are found at 193—7.4(17A,272C).

This rule is intended to implement Iowa Code sections 542B.21, 542B.22 and 272C.6.

193C—9.3(17A,272C,542B,546) Grounds for discipline. The board may initiate disciplinary action against a licensee holding an active, inactive or lapsed license on any of the following grounds:

9.3(1) Fraud or deceit in procuring a license. Fraud or deceit in procuring or attempting to procure an initial, comity, renewal, or reinstated license includes any intentional perversion of or reckless disregard for the truth when an application, or information in support of another's application, is submitted to the board, including:

a. False representation of a material fact, whether by word or by conduct, by false or misleading allegation, or by concealment of that which should have been disclosed.

b. Attempting to file or filing with the board any false or forged record or document, such as a college transcript, diploma or degree, examination report, verification of licensure, or continuing education certificate.

c. Reporting information, such as satisfaction of continuing education, in a false manner, through overt deceit, or with reckless disregard for the truth or accuracy of the information asserted.

d. Otherwise participating in any form of fraud or misrepresentation by act or omission.

9.3(2) Professional incompetence. Professional incompetence includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the practice of engineering or land surveying.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care which is ordinarily exercised by the average practitioner acting in the same or similar circumstances.

d. Failure to conform to the minimum standards of acceptable and prevailing practice of engineering or land surveying in this state, including the land surveying standards set forth in Iowa Code chapters 354 and 355 and 193C—Chapters 11 and 12.

e. Engaging in engineering or land surveying practices which are outside the technical competence of the licensee without taking reasonable steps to associate with a competent licensee or other steps to ensure competent practice.

f. Any other act or omission that demonstrates an inability to safely practice in a manner protective of the public's interest, including acts or omissions described in 193C—8.3(542B).

9.3(3) Deceptive practices. Deceptive practices are grounds for discipline, whether or not actual injury is established, and include, but are not limited to, the following:

a. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of engineering or land surveying.

b. Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

c. Acceptance of any fee by fraud or misrepresentation.

d. Falsification of business or client records.

e. Submission of false or misleading reports or information to the board including information supplied in an audit of continuing education or as a condition of probation, or in a reference submitted for an examination or a license applicant or in any reports identified in this rule or 193C—8.3(542B).

f. Knowingly presenting as one's own the license, signature, or seal of another or of a fictitious licensee, or otherwise falsely impersonating a person holding an engineering or land surveying license.

g. Representing oneself as a professional engineer or professional land surveyor after the license has been suspended, revoked, surrendered, or placed on inactive status or has lapsed.

h. Fraud in representations as to skill or ability.

i. Any violation of Iowa Code section 542B.16 or associated rules in 193C—Chapter 6 involving a licensee's seal or certificate.

9.3(4) Unethical, harmful or detrimental conduct. Licensees engaging in unethical conduct or practices harmful or detrimental to the public may be disciplined whether or not injury is established. Behaviors and conduct which are unethical or harmful or detrimental to the public include, but are not limited to, the following actions:

a. A violation of the code of professional conduct in 193C—Chapter 8.

b. Verbal or physical abuse, or improper sexual contact, if such behavior occurs within the practice of engineering or land surveying or if such behavior otherwise provides a reasonable basis for the board to conclude that such behavior could occur within such practice and, if so, would place the public at risk.

c. Aiding or abetting a violation of a provision of Iowa Code section 542B.27(1).

9.3(5) Lack of proper qualifications. Lack of proper qualifications includes, but is not limited to:

a. Continuing to practice as an engineer or land surveyor without satisfying the continuing education required for license renewal.

b. Habitual use of or addiction to alcohol or other drugs, or other impairment, which adversely affects the licensee's ability to practice in a safe and competent manner.

c. As provided in Iowa Code section 272C.3(2) "b," any act, conduct, or condition, including lack of education or experience, or a pattern of careless or intentional acts or omissions that demonstrate a lack of qualifications which are necessary to ensure a high standard of professional care or that impair a practitioner's ability to safely and skillfully practice the profession.

9.3(6) Professional misconduct. Professional misconduct includes, but is not limited to, the following:

a. Engaging in any conduct that subverts or attempts to subvert a board investigation of a licensee, license applicant, or unlicensed firm, individual, or other entity.

b. Failure to fully cooperate with a disciplinary investigation of a licensee or license applicant or with an investigation of firms, individuals or other entities that are not licensed by the board.

c. Failure to comply with a subpoena issued by the board or to respond to a board inquiry within 30 calendar days of the date of mailing by certified mail of a written communication directed to the licensee's last address on file with the board.

d. Revocation, suspension, or other disciplinary action taken against a licensee by a licensing authority of this state or another state, territory, or country. A "disciplinary action" includes a voluntary surrender of a license to resolve a pending disciplinary investigation or proceeding. A stay by an appellate

court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, discipline by the board based solely on such action shall be vacated.

e. Violation of the terms of an initial agreement with an impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with an impaired practitioner review committee.

f. Engaging in the practice of engineering or land surveying while the person's license is lapsed or inactive.

g. Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order or other board decision imposing discipline.

h. The board's receipt of a notice of noncompliance, as more fully described in rules 193—7.43(252J) (child support), 193—7.44(261) (student loans), and 193—7.45(272D) (state debt).

9.3(7) Willful or repeated violations. Willful or repeated violations include the willful or repeated violation or disregard of any provision of Iowa Code chapter 272C or 542 or any administrative rule adopted by the board in the administration or enforcement of such chapters.

9.3(8) Conviction of felony. Conviction of felony includes the conviction of a felony under the laws of the United States, of any state or possession of the United States, or of any other country. If such conviction is overturned or reversed by a court of last resort, discipline by the board based solely on the conviction shall be vacated.

[ARC 2022C, IAB 6/10/15, effective 7/15/15]

193C—9.4(542B) Disciplinary findings and sanctions. The board's decision may include one or more of the following findings or sanctions:

1. Exoneration of respondent.
2. Revocation of license.
3. Suspension of license until further order of the board or for a specified period.
4. Nonrenewal of license.
5. Prohibition, until further order of the board or for a specific period, of engaging in specified procedures, methods or acts.
6. Probation.
7. Requirement of additional education or training.
8. Requirement of reexamination.
9. Issuance of a reprimand.
10. Imposition of civil penalties.
11. Issuance of citation and warning.
12. Desk review.
13. Other sanctions allowed by law as may be appropriate.

193C—9.5(272C) Civil penalties. In addition to other disciplinary options, the board may assess civil penalties of up to \$1000 per violation against licensees who violate any provision of rule 193C—9.3(17A,272C,542B,546). Factors the board may consider when determining whether and in what amount to assess civil penalties include:

1. Whether other forms of discipline are being imposed for the same violation.
2. Whether the amount imposed will be a substantial economic deterrent to the violation.
3. The circumstances leading to the violation.
4. The severity of the violation and the risk of harm to the public.
5. The economic benefits gained by the licensee as a result of the violation.
6. The interest of the public.
7. Evidence of reform or remedial action.
8. Time elapsed since the violation occurred.
9. Whether the violation is a repeat offense following a prior cautionary letter, disciplinary order, or other notice of the nature of the infraction.
10. The clarity of the issue involved.

11. Whether the violation was willful and intentional.
12. Whether the licensee acted in bad faith.
13. The extent to which the licensee cooperated with the board.
14. Whether the licensee practiced professional engineering or professional land surveying with a lapsed, inactive, suspended or revoked license.

This rule is intended to implement Iowa Code section 542B.22.
[ARC 0362C, IAB 10/3/12, effective 11/7/12]

193C—9.6(542B) Publication of decisions. In addition to publication requirements found at 193—subrule 7.30(3), the following notifications shall be issued:

1. Following suspension of a professional land surveyor's license, notification must be mailed to the county recorders and county auditors of the county of residence and immediately adjacent counties in Iowa.
2. Following revocation of a professional land surveyor's license, notification must be mailed to all county auditors in Iowa and the county recorders in the county of residence and immediately adjacent counties in Iowa.
3. Following the suspension or revocation of the license of a professional engineer or professional land surveyor, notification must be issued to other boards of examiners for engineers and land surveyors under the jurisdiction of the government of the United States. This notification may be made through the National Council of Examiners for Engineering and Surveying or other national organizations recognized by the board. In addition, if the licensee is known to be registered in another nation in North America, the appropriate board(s) shall be notified of the action.

[ARC 0362C, IAB 10/3/12, effective 11/7/12]

193C—9.7(542B) Disputes between licensees and clients. Reports from the insurance commissioner or other agencies on the results of judgments or settlements of disputes arising from malpractice claims or other actions between professional engineers or professional land surveyors and their clients may be referred to counsel or peer review committee. The counsel or peer review committee shall investigate the report for violation of the statutes or rules governing the practice or conduct of the licensee. The counsel or peer review committee shall advise the board of any probable violations, any further action required, or recommend dismissal from further consideration.

[ARC 0362C, IAB 10/3/12, effective 11/7/12]

193C—9.8(272C,542) Confidentiality of complaint and investigative information.

9.8(1) General provisions. All complaint and investigative information received or created by the board is privileged and confidential pursuant to Iowa Code section 272C.6(4). Such information shall not be released to any person except as provided in that section.

9.8(2) Disclosure to the subject of the investigation.

a. Legal authority. Pursuant to Iowa Code Supplement section 546.10(9) [2007 Iowa Acts, Senate File 360, section 7], the board may supply to a licensee who is the subject of a disciplinary complaint or investigation, prior to the initiation of a disciplinary proceeding, all or such parts of a disciplinary complaint, disciplinary or investigatory file, report, or other information, as the board in its sole discretion believes would aid the investigation or resolution of the matter.

b. General rule. As a matter of general policy, the board shall not disclose confidential complaint and investigative information to a licensee except as permitted by Iowa Code section 272C.6(4). Disclosure of a complainant's identity in advance of the filing of formal disciplinary charges, for instance, may adversely affect a complainant's willingness to file a complaint with the board.

c. Exceptions to general rule. The board may exercise its discretion to release information to a licensee that would otherwise be confidential under Iowa Code section 272C.6(4) under narrow circumstances, including but not limited to the following:

(1) Following a board determination that probable cause exists to file disciplinary charges against a licensee and prior to the issuance of the notice of hearing, the board may provide the licensee with a

peer review or investigative report or expert opinions, as reasonably needed for the licensee to assess the merits of a settlement proposal.

(2) The board may release to a licensee who is the subject of a board-initiated investigation, including those initiated following the board's receipt of an anonymous complaint, such records or information as may aid the investigation or resolution of the matter.

(3) The board may release information from a peer review or consultant's report when soliciting the licensee's position will aid in making the probable cause determination and such disclosure can be made to the licensee without revealing identifying information regarding the complainant, peer reviewer or consultant.

These rules are intended to implement Iowa Code chapter 17A and sections 542B.2, 542B.22, and 272C.6.

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TITLE III
COMMUNITY COLLEGES
CHAPTER 21
COMMUNITY COLLEGES

[Prior to 9/7/88, see Public Instruction Department[670] Ch 5]
[Former Ch 21 Rescinded, IAB 9/7/88]

DIVISION I
APPROVAL STANDARDS

281—21.1(260C) Definitions. For purposes of this chapter, the indicated terms are defined as follows:

“*Department*” means the Iowa department of education.

“*Director*” means the director of the department.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.2(260C) Administration.

21.2(1) *Policy manual.* A community college board of directors shall develop and maintain a policy manual which adequately describes the official policies of the institution.

21.2(2) *Administrative staff.* A community college shall develop an administrative staff appropriate to the size and the purpose of the institution and one which permits the institution to function effectively and efficiently. This administrative staff shall provide effective leadership for the major divisions of the institution including administrative services, adult and continuing education, career and technical education, college parallel education, and student services.

21.2(3) *Chief executive officer.* A community college shall have a chief executive officer who shall also be the executive officer of the board of directors. The executive officer shall be responsible for the operation of the community college with respect to its educational program, its faculty and student services programs, and the use of its facilities. The executive officer shall delegate to the staff all necessary administrative and supervisory responsibilities to ensure an efficient operation of the institution.

21.2(4) *Financial records and reports.* The community college shall maintain accurate financial records and make reports in the form and pursuant to the timeline prescribed by the department and other state agencies.

21.2(5) *Enrollment.* A community college shall meet minimum enrollment requirements if it offers instruction as authorized in Iowa Code chapter 260C, and if, to the satisfaction of the state board of education, it is able to provide classes of reasonable economic size as needed by students, meets the needs of the students, and shows by its past and present enrollment and placement record that it meets individual and employment needs.

21.2(6) *Catalog.* The catalog shall be the official publication of the community college. It shall include accurate information on institutional policies, admissions requirements, procedures and fees, refund policies, residency requirements, program enrollment and degree requirements, due process procedures, affirmative action, and other information as recommended by the department. Students’ rights and responsibilities may be included in the catalog or in a separate document.

21.2(7) *Admissions and program/course enrollment requirements.* The community college shall maintain an open-door admission policy for students of postsecondary age. This admission policy shall recognize that students should demonstrate a reasonable prospect for success in the program in which they are admitted. Applicants who cannot demonstrate a reasonable prospect for success in the program for which they apply should be assisted to enroll in courses where deficiencies may be remediated or into programs appropriate to the individual’s preparation and objectives. The community college may set reasonable requirements for student enrollment in specified programs and courses. Admissions and program enrollment requirements established by each community college shall be published in the community college catalog.

21.2(8) *Academic year.* The academic year of the community college shall consist of semester, trimester, or quarter terms, and shall be a period of time beginning with the first day of the fall term and

continuing through the day preceding the start of the next fall term as indicated in the official college calendar. A community college may offer instruction in units of length (i.e., days and weeks) consistent with the identified scope and depth of the instructional content.

21.2(9) Award requirements. The director shall approve all new credit certificate, diploma, and degree award programs in accordance with Iowa Code section 260C.14. Awards from a community college shall be certified by the issuance of appropriate recognition, pursuant to award approval requirement guidelines issued by the department, indicating the type of program the student has completed. The minimum number and maximum number of credit hours required for each award type contained within this subrule may be waived pursuant to paragraph 21.2(13) "i." Each award shall meet the expectations of statewide articulation agreements between Iowa community colleges and public universities.

a. Associate of arts (AA). The degree is awarded upon completion of a college parallel (transfer) course of study that provides a strong general education component to satisfy the lower division general education liberal arts and sciences requirements for a baccalaureate degree. An associate of arts degree shall consist of a minimum of 60 semester (90 quarter) credit hours and a maximum of 64 semester (96 quarter) credit hours.

b. Associate of science (AS). The degree is awarded upon completion of a course of study that requires a strong background in mathematics or science. The degree is intended to prepare students to transfer and initiate upperdivision work in baccalaureate programs. An associate of science degree awarded upon completion of an arts and sciences course of study shall consist of a minimum of 60 semester (90 quarter) credit hours and a maximum of 64 semester (96 quarter) credit hours.

c. Associate of general studies (AGS). The degree is awarded upon completion of an individualized course of study that is primarily designed for the acquisition of a broad educational background rather than the pursuit of a specific college major or professional/technical program. The AGS is intended as a flexible course of study and may include specific curriculum in lower division transfer, occupational education, or professional-technical education. It shall not include a marketed course of study. An associate of general studies degree shall consist of a minimum of 60 semester (90 quarter) credit hours and a maximum of 64 semester (96 quarter) credit hours.

d. Associate of applied science (AAS). The degree is awarded upon completion of a state-approved program of study that is intended to prepare students for entry-level career and technical occupations. An associate of applied science degree shall consist of a minimum of 60 semester (90 quarter) credit hours and a maximum of 86 semester (129 quarter) credit hours. The general education component of the associate of applied science degree program shall consist of a minimum of 12 semester (18 quarter) credit hours of general education and shall include at least one course from each of the following areas: communications, social science or humanities, and mathematics or science. The technical specialty component of the associate of applied science degree shall constitute a minimum of 50 percent of the course credits.

e. Associate of applied arts (AAA). The degree is awarded upon completion of a state-approved program of study that is primarily intended for career training in providing students with professional skills for employment in a specific field of work such as arts, humanities, or graphic design. An associate of applied arts degree shall consist of a minimum of 60 semester (90 quarter) credit hours and a maximum of 86 semester (129 quarter) credit hours. The general education component of the associate of applied arts degree program shall consist of a minimum of 12 semester (18 quarter) credit hours of general education and shall include at least one course from each of the following: communications, social science or humanities, and mathematics or science. The technical specialty component of the associate of applied arts degree shall constitute a minimum of 50 percent of the course credits.

f. Associate of professional studies (APS) pilot. The degree is awarded upon completion of a state-approved program of study that is intended to prepare students for transfer and upper division coursework in aligned baccalaureate programs or immediate entry into the workforce.

(1) Pilot awards shall be approved on a limited basis at the director's sole discretion. To be eligible to participate in the pilot, a college shall demonstrate that other award types cannot meet needs and the associate of professional studies award is appropriate. The department shall study the effectiveness of

associate of professional studies programs with regard to transfer and employment success after five years and make recommendations to the state board of education regarding program parameters and continuation.

(2) Each state-approved associate of science-career option (AS-CO) program of study shall be phased out by the end of the 2015-2016 academic year. All existing AS-CO programs shall be modified to meet the parameters of allowable award types or shall be discontinued.

(3) An associate of professional studies degree shall consist of a minimum of 62 semester (93 quarter) credit hours and a maximum of 68 semester (102 quarter) credit hours. The general education component of the associate of professional studies degree shall consist of a minimum of 30 semester (45 quarter) credit hours of general education including 3 semester (4.5 quarter) credit hours of each of the following: speech, mathematics, humanities, social and behavioral sciences, science; 6 semester (9 quarter) credit hours of writing; and 9 semester (13.5 quarter) credit hours distributed among mathematics, social and behavioral sciences, humanities, and science. The technical specialty component of the associate of professional studies degree shall consist of a minimum of 16 semester (24 quarter) credit hours of career and technical coursework accepted by a receiving baccalaureate degree-granting institution with an aligned program as applying toward a specific major or program of study. The technical specialty component of the degree shall also consist of a minimum of 16 additional semester (24 quarter) credit hours of career and technical coursework accepted by the receiving institution as electives.

(4) An associate of professional studies degree program of study shall have a minimum of three program-to-program articulation agreements with baccalaureate degree-granting institutions, at least one of which must be a public institution. A program shall have a minimum of one articulation agreement effective prior to program implementation, provided all three agreements are effective within the program's first year of student enrollment. The agreements shall provide for the application of no fewer than 60 semester (90 quarter) credit hours toward the graduation requirements of each articulated baccalaureate degree program.

g. Diploma. The diploma is awarded upon completion of a state-approved program of study that is a coherent sequence of courses consisting of a minimum of 15 semester (22.5 quarter) credit hours and a maximum of 48 semester (72 quarter) credit hours including at least 3 semester (4.5 quarter) credit hours of general education. The general education component shall be from any of the following areas: communications, social science or humanities, and mathematics or science. A diploma may be a component of and apply toward subsequent completion of an associate of applied science or associate of applied arts degree.

h. Certificate. The certificate is awarded upon completion of a state-approved program of study that is designed for entry-level employment and shall consist of a maximum of 48 semester (72 quarter) credit hours. A certificate may be a component of and apply toward subsequent completion of a diploma or associate of applied science or associate of applied arts degree and may be developed in rapid response to the needs of business and industry. A certificate may consist of only career and technical courses and no general education course requirements.

21.2(10) Academic records. The community college shall maintain in perpetuity for each student the complete academic record including every course attempted and grade received. An official transcript must be created at the time of course enrollment. The credit hour(s) and grade must be recorded on the student's official transcripts upon completion of a community college course. These records shall be kept in disaster-resistant storage, unless other equivalent safeguards are used, such as maintaining duplicate files (electronic or otherwise) in separate facilities. The method of storage shall be consistent with current technology to ensure the ability to retrieve records. The community college shall implement a security plan that ensures the confidentiality of student records.

21.2(11) Residency status and tuition. A student who has been admitted to an Iowa community college shall be classified as a resident or as a nonresident for admission, tuition, and fee purposes. A student classified as a resident shall pay resident tuition costs. A student classified as a nonresident shall pay nonresident tuition costs. Tuition rates are established by a community college's board of trustees pursuant to Iowa Code section 260C.14(2).

a. Tuition rates. Tuition rates adopted by a community college's board of trustees shall be consistent with the following requirements.

(1) Resident tuition.

1. Tuition for residents shall not exceed the lowest tuition rate per semester, or the equivalent, for a full-time student charged by an institution of higher education under the state board of regents.

2. For students of high school age enrolled in a course through a contractual agreement with a school district, the limit on resident tuition shall not apply, and the amount of tuition shall be determined by the community college's board of trustees with the consent of the school board.

3. Resident tuition rates shall not require department approval.

(2) Nonresident tuition. Tuition for nonresidents shall be not less than the marginal cost of instruction of a student attending the college. The establishment of nonresident tuition rates shall not require department approval, with the exception of rates established pursuant to paragraphs 21.2(11) "a"(2) "2" and "3" and 21.2(11) "a"(3).

1. International student tuition rates. A separate nonresident rate for international students shall be permissible, provided the rate is reasonable and reflects the cost of appropriate services.

2. Reciprocal agreements. A lower tuition rate for nonresidents is permitted under a reciprocal tuition agreement between a community college and an educational institution in another state, if the rate established in the agreement is approved by the department.

3. Other nonresident rates. Other nonresident tuition rates may be established for specific purposes provided the tuition rate is greater than the resident tuition rate, the tuition rate is not less than the marginal cost of instruction, and the arrangement is approved by the department.

(3) Consortia. A separate tuition rate for residents and nonresidents is permitted for courses delivered through a consortia agreement for online, distance education, or other coursework between Iowa community colleges, if the rate established in the agreement is approved by the department. Tuition shall not be less than the lowest resident rate or higher than the highest nonresident rate of institutions within the consortium.

(4) Noncredit course tuition. Tuition for noncredit continuing education courses shall be determined based on course costs and market demand. Tuition rates for courses that are not credit-bearing shall not require department approval.

(5) Department approval. For tuition rates requiring department approval, the department shall approve rates which comply with the requirements set forth in this chapter. Before a rate is adopted by a community college's board of trustees and charged to students, the community college shall request and receive approval for a tuition rate.

(6) Reporting. A community college shall annually report all tuition rates and mandatory fees in a manner prescribed by the department.

(7) Notification. A community college shall inform all students about residency status determinations, the appeal process, and tuition policies. Information shall be included in appropriate publications such as the college's catalog, registration materials, Web site, and student handbook.

b. Determination of residency status. In determining a community college resident or nonresident classification, the primary determinant shall be the reason the student is in the state of Iowa. The second determinant shall be the length of time a student has resided in Iowa. If a student is in the state primarily for educational purposes, that student shall be considered a nonresident. The burden of establishing the reason a student is in Iowa for other than educational purposes rests with the student.

(1) Procedure. The registrar or officially designated community college office shall require written documents, affidavits, or other related evidence deemed necessary to determine why a student is in Iowa. A student shall be required to file at least two documents from different sources to determine residency status. Examples of acceptable documentation include: written and notarized documentation from an employer that the student is employed in Iowa or a signed and notarized statement from the student describing employment and sources of support; an Iowa state income tax return; an Iowa driver's license; an Iowa vehicle registration card; an Iowa voter registration card; or proof of Iowa Homestead credit on property taxes. In all events, to be determined a resident of Iowa, the student must document residing in the state of Iowa for at least 90 days prior to the beginning of the term for which the student is enrolling.

1. If a student gives misleading or incorrect information for the purpose of evading payment of nonresident tuition, the student must pay the nonresident tuition for each term the student was not officially classified as a nonresident.

2. The procedures described in paragraph 21.2(11)“b” shall be administered by the registrar or staff designated by the community college.

(2) Residency of minor students. The domicile of a minor shall follow that of the parent with whom the minor resides, except where emancipation of said minor can be proven. The word “parent” herein shall include legal guardian or others in cases where the lawful custody of a minor has been awarded to persons other than the minor’s actual parents. A minor living with a resident of Iowa who is legally responsible for the minor shall be granted resident status if the minor has lived with the Iowa resident for at least 90 days immediately prior to enrollment. The residency status of an emancipated minor shall be based upon the same qualifications established for a student having attained majority.

(3) Residency of students who are not citizens of the United States. The residency status of students who are not citizens of the United States shall be determined consistent with the following procedures.

1. A student who is a refugee or who is granted asylum by an appropriate agency of the United States must provide proof of certification of refugee or asylum grantee status. A student may be accorded resident status for admission and tuition purposes when the student comes directly, or within a reasonable time, to the state of Iowa from a refugee facility or port of debarkation and has not established domicile in another state.

2. A student who has immigrant status, and the student’s spouse or dependents, may establish Iowa residency in the same manner as a United States citizen.

3. A student who has nonimmigrant status and who holds a nonstudent visa, and the student’s spouse or dependents, may establish residency in the same manner as a United States citizen. An alien who has nonimmigrant status and whose primary purpose for being in Iowa is educational is classified as nonresident.

4. A student who is a resident of an Iowa sister state may be classified as a resident or nonresident, in accordance with rules adopted by the college’s board of directors.

(4) Residency of federal personnel and dependents. A student, or the student’s spouse or dependent child, who has moved into the state of Iowa as the result of military or civil orders from the federal government, and the minor children of such student, is immediately an Iowa resident.

(5) Residency of veterans and family members and individuals covered under Section 702 of the Veterans Access, Choice and Accountability Act of 2014. A veteran of a uniformed service, a member of the National Guard, or the veteran’s or member’s spouse or dependent child shall be classified as an Iowa resident student and be eligible for resident tuition and fee amounts, if the veteran or national guard member meets the requirements of paragraph 21.2(11)“b”(5)“1,” “2,” or “3.”

1. The veteran has separated from a uniformed service with an honorable or general discharge, is eligible for benefits, or has exhausted benefits under the federal Post-9/11 Veterans Educational Assistance Act of 2008 or any other federal authorizing veteran educational benefits program.

2. The individual is an active duty military person or activated or temporarily mobilized National Guard member.

3. The individual is a covered person under Section 702 of the Veterans Access, Choice and Accountability Act of 2014 or subsequent legislation.

(6) Reclassification of residency status. It is the responsibility of a student to request a reclassification of residency status. If a student is reclassified as a resident for tuition purposes, such classification shall be effective beginning with the next term for which the student enrolls. In no case shall reclassification to residency status be made retroactive for tuition and fee purposes, even though the student could have previously qualified for residency status had the student applied.

(7) Appeal. The decision on the residency status of a student for admission, tuition, and fee purposes may be appealed to a review committee established by the community college. The findings of the review committee may be appealed to the community college’s board of trustees, whose decision shall be a final administrative decision.

21.2(12) Credit hours. Credit hours shall be determined consistent with the following procedures.

a. Specifically stated criteria are minimal requirements only, which institutions may exceed at their discretion.

b. Conventional instruction is subdivided into four instructional methods as herein defined.

(1) Classroom work — lecture and formalized classroom instruction under the supervision of an instructor.

(2) Laboratory work — experimentation and practice by students under the supervision of an instructor.

(3) Clinical practice — applied learning experience in a health agency or office under the supervision of an instructor.

(4) Work experience — employment-related experience planned and coordinated by an institutional representative and the employer, with control and supervision of the student on the job being the responsibility of the employer.

c. No registration or orientation hours may be included when determining credit hours.

d. Institutions shall take into account the soundness of the learning environment being created by the scheduling sequence and length of classroom, laboratory, clinical, and work experience sessions. However, the final decision on these matters is left to the institutional administration so long as minimal standards are met.

e. Only minutes for students officially registered for courses or programs, including audit registration, may be included when determining credit hours.

f. Each community college must establish a policy that defines its methods of equating alternative instruction to credit hours and the process for evaluating the effectiveness of the alternative instruction to meet or exceed the expected student outcomes as if the course were taught utilizing conventional methods in paragraph 21.2(12)“*b.*” Colleges will be held accountable for evaluating and maintaining high-quality programs, and their evaluations may be subject to department review. Students shall be expected to meet all approved course requirements and shall be expected to demonstrate the acquisition of knowledge and competencies/outcomes at the same level as those obtained in traditional classroom settings, in the time frames set by the institution. Alternative courses or programs of study must be approved by the college’s review processes including faculty review and input. Courses shall be listed in the college catalog. Instructional formats for which alternative methods of determining credit hours are applicable include the following:

(1) Accelerated courses (study, programs). Courses or programs of study that allow students to complete courses or programs at a faster pace than if offered by conventional methods. Courses and programs shall be tailored to involve more student participation and self-directed study. Instructors may teach in traditional classroom settings or by alternative methods specified in this subrule.

(2) Distance education. Courses or programs of study taught over the Internet, Iowa Communications Network (ICN), or other electronic means that allow students to receive instruction in the classroom or other sites, over personal computers, television, or other electronic means. Courses may or may not be interactive with direct communication between the teacher and students. Credit hours shall be awarded in accordance with the credit hours that would have been assigned if the course or program were taught by conventional methods.

1. Correspondence courses. Courses offered outside the classroom setting in which the instruction is delivered indirectly to the student. Instruction is provided through another medium, such as written material, computer, television, or electronic means. Course materials are sent to a student who follows a detailed syllabus to complete assignments. Students correspond with and transmit assignments to the instructor by telephone, computer, mail, or electronic means. A third party may administer tests.

2. Television courses. Courses or programs delivered primarily via broadcast television such as Iowa Public Television, digital video disc, or other media allowing students to receive instruction in a classroom or equipped remote location.

3. Video conference courses. Courses or programs delivered via a closed synchronous audio-video conferencing system such as the Iowa Communications Network or similar system which allows students to receive instruction in a classroom or any equipped remote location via an audio-video feed to a television, computer, or other electronic device.

4. Internet courses. Courses or programs delivered via the Internet. Courses may be taken using computers in a classroom setting or using personal computers or other electronic devices from the student's home or other location using an online content management system or mixed-media methods. Students may be linked at times directly with the instructor or with other students electronically. Interaction may be direct (synchronous) or indirect (asynchronous) allowing students to participate during their own time frames.

5. In-class hybrid courses. Courses or programs that combine traditional classroom and computer-based instruction. In-class sessions are offered with online instructional activities to promote independent learning and reduce seat-time.

(3) Self-paced instruction. Courses or programs that permit a student to enter at variable times or progress at the student's own rate of speed. Start and end dates may or may not correspond to the official college calendar. Contact or credit hours for self-paced programs or courses shall be computed by assigning to each registration the total number of credit or contact hours the student would have received if the student enrolled in a conventional program or course with stipulated beginning and ending dates.

(4) Arranged study. Instruction offered to students at times other than stated or scheduled class times to accommodate specific scheduling or program needs of students. Credit hours shall be awarded in accordance with the credit hours that would have been assigned if the course or program were taught by conventional methods.

(5) Multiformat nontraditional instruction. Instruction utilizing a variety of nontraditional methods that may incorporate self-paced learning, text, video, computer instructional delivery, accelerated training, independent study, Internet delivery, or other methods that do not follow standard classroom work guidelines. Credit hours shall be awarded in accordance with the credit hours that would have been assigned if the course or program were taught by conventional methods.

g. Individualized learning experiences for which an equivalent course is not offered shall have the program length computed from records of attendance using such procedures as a time clock or sign-in records. Individualized learning experiences means independent study courses in which an equivalent course is not offered by the college or listed in the college catalog. Independent study permits in-depth or focused learning on special topics of particular interest to the student.

h. Each course must have a minimum length of one credit hour. A fractional unit of credit may be awarded provided the course exceeds the minimum length of one credit hour.

i. Each credit hour shall consist of a minimum number of contact hours as defined in paragraphs 21.2(12) "h" to "m." One contact hour equals 50 minutes.

j. Classroom work.

(1) The minimal requirement for one semester hour of credit shall be 800 minutes (16 contact hours) of scheduled instruction.

(2) The minimal requirement for one quarter hour of credit shall be 533 minutes (10.7 contact hours) of scheduled instruction.

k. Laboratory work.

(1) The minimal requirement for one semester hour of credit shall be 1,600 minutes (32 contact hours) of scheduled laboratory work.

(2) The minimal requirement for one quarter hour of credit shall be 1,066 minutes (21.3 contact hours) of scheduled laboratory work.

l. Clinical practice.

(1) The minimal requirement for one semester hour of credit shall be 2,400 minutes (48 contact hours) of scheduled clinical practice.

(2) The minimal requirement for one quarter hour of credit shall be 1,599 minutes (32 contact hours) of scheduled clinical practice.

m. Work experience.

(1) The minimal requirement for one semester hour of credit shall be 3,200 minutes (64 contact hours) of scheduled work experience.

(2) The minimal requirement for one quarter hour of credit shall be 2,132 minutes (42.6 contact hours) of scheduled work experience.

21.2(13) Career and technical program length.

a. Program length for the associate of applied science (AAS) degree in career and technical education, for the associate of applied arts (AAA) degree, and for the associate of professional studies (APS) degree shall consist of an academic program not to exceed two academic years. All required course offerings are to be available within two academic years. All required offerings in AAS and AAA degree programs shall not exceed a maximum of 86 semester (129 quarter) credit hours unless the department of education has granted a waiver pursuant to paragraph 21.2(13)“i.” All required offerings in pilot APS degree programs shall not exceed a maximum of 68 credit hours. Programs shall not exceed an average of 19 credit hours per regular term.

b. All credit-bearing courses required for program admittance or graduation, or both, shall be included in the program length credit hour maximum, with the exception of developmental course credit hours. Prerequisites that provide an option to students for either credit or noncredit shall be counted toward the program parameters. Prerequisite options that are only offered for noncredit shall not be counted toward program length parameters. A high school course prerequisite is permissible and shall not count toward program length parameters, provided the prerequisite is reasonable. A high school course prerequisite is reasonable if a community college demonstrates that students entering the program predominantly meet the requirement without prior college coursework.

c. Associate of applied science (AAS) and associate of applied arts (AAA) programs that receive accreditation from nationally recognized accrediting bodies may appeal maximum credit hour length requirements to the department for consideration of a waiver. All AAS and AAA degree programs over the 86 semester (129 quarter) credit hour maximum must have approved program-length waivers pursuant to paragraph 21.2(13)“i.”

d. Associate of professional studies pilot programs shall not be eligible for a program-length waiver pursuant to paragraph 21.2(13)“i.”

e. All credit certificate and diploma programs as defined in subrule 21.2(9) shall not exceed 48 semester (72 quarter) credit hours.

f. Each course offered in the area of career and technical education shall be taught in the shortest practical period of time at a standard consistent with the quality and quantity of work needed to prepare the student for successful employment in the occupation for which instruction is being offered.

g. A full-time student in career and technical education shall be defined as a student enrolling in 12 or more semester credit hours or the equivalent in career and technical education.

h. Curricula in full-time career and technical education programs shall ordinarily be offered on the basis of student workload of 20 to 30 contact hours per week.

i. Waiver process. A college may petition the department to suspend in whole or in part a program-length requirement contained in paragraphs 21.2(13)“a” to “e” as applied to a specific program on the basis of the particular circumstances of that program.

(1) Waivers shall be issued at the director’s sole discretion. Waivers shall be narrowly tailored and granted for a period no longer than two academic years, after which reapplication is required. A waiver may be granted on a long-term basis not to exceed ten years if issuing the waiver for a shorter period is not practical.

(2) All petitions for waiver must be submitted in writing to the department. A petition shall include the following information: specific waiver request including scope and duration, the relevant facts that the petitioner believes would justify a waiver, a detailed statement of the impact on student achievement, any information known regarding the department’s treatment of similar cases, and any additional information deemed relevant by the petitioner. The department shall acknowledge a petition upon receipt.

(3) The department shall ensure that, within 30 calendar days, notice of pendency of the petition and a concise summary of its contents have been provided to a committee consisting of the chief academic officers of each community college. In addition, the department may give notice to other persons.

(4) A committee consisting of the chief academic officers of a majority of community colleges shall review the waiver request and provide a recommendation to the department regarding whether approval should be granted. Within 90 calendar days of receiving the recommendation, the department

shall review the petition and issue a ruling. Failure of the department to grant or deny a petition within the required time period shall be deemed a denial of that petition. If a waiver is issued, the department shall provide a description of the precise scope and operative period to all interested parties.

21.2(14) Faculty organization. The faculty shall be organized in such a way as to promote communication among administration, faculty and students and to encourage faculty participation in the development of the curriculum, instructional procedures, general policies, and such other matters as are appropriate.

21.2(15) Faculty salary allocation plan. Pursuant to the appropriation of funds from the state general fund to the department for the purpose of supplementing community college faculty salaries, the department follows the formula herein when distributing such funds to community colleges.

a. For purposes of this subrule, the following definitions apply.

(1) “Full-time faculty” means those nonadministrative instructors, counselors, and librarians who are classified as full-time employees as defined in the college’s collective bargaining agreement or written policy.

(2) “Part-time faculty” means those nonadministrative instructors, counselors, and librarians who are employed less than full-time as defined in the college’s collective bargaining agreement and who are covered by the college’s collective bargaining agreement. For purposes of the definition of “eligible full-time equivalent instructor,” each part-time faculty person shall be counted as a fraction that accurately reflects the person’s percentage of employment by the college when compared to a full-time faculty person.

(3) “Temporary/seasonal faculty” means those nonadministrative instructors, counselors, and librarians who are employed, full-time or part-time, by the college for short periods of time for specific purposes.

(4) “Adjunct faculty” means those nonadministrative instructors, counselors, and librarians who are employed without a continuing contract, whose teaching load does not exceed one-half time for two full semesters or three full quarters per calendar year.

(5) “Eligible full-time equivalent instructor” means the total of full-time faculty and part-time faculty where each full-time faculty counts as one, and each part-time faculty counts as a fraction that accurately reflects the person’s percentage of employment by the college when compared to a full-time faculty person.

b. The appropriation shall be distributed to the community colleges based on their proportional share of eligible full-time equivalent instructors.

c. Moneys distributed to each community college pursuant to this subrule shall be rolled into the funding allocation for all future years. The use of the funds shall remain as described herein for all future years. The appropriation will be distributed to the community colleges in equal monthly payments made on or about the fifteenth of each month.

d. Moneys appropriated and distributed to community colleges pursuant to this subrule shall be used to supplement and not supplant any approved faculty salary increases or negotiated agreements, excluding the distribution of the funds herein. Eligible expenditures for the moneys appropriated are for salary expenditures and the required college contribution to FICA and IPERS or an alternative retirement benefits system. These moneys shall then be considered as part of the instructor’s salary in future years.

e. Moneys distributed to a community college pursuant to this subrule shall be allocated to all full-time faculty and shall include part-time faculty covered by a collective bargaining agreement. The moneys shall be allocated pursuant to any existing negotiated agreements according to Iowa Code chapter 20. If no language exists to specify the method of allocation, the moneys shall be allocated equally to all full-time faculty with part-time faculty who are covered by a collective bargaining agreement receiving a prorated share.

f. A community college receiving funds distributed pursuant to this subrule shall determine the amount to be paid to instructors in accordance with Iowa Code section 260C.18D, subsection 4, and the

amount determined to be paid to an individual instructor shall be divided evenly and paid in each pay period of the fiscal year.

This rule is intended to implement Iowa Code section 260C.33.

[ARC 8646B, IAB 4/7/10, effective 5/12/10; ARC 0687C, IAB 4/17/13, effective 5/22/13; ARC 2021C, IAB 6/10/15, effective 7/15/15]

281—21.3(260C) Faculty. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.4(260C) Curriculum and evaluation.

21.4(1) General education. General education is intended to provide breadth of learning to the community college experience. General education imparts common knowledge, promotes intellectual inquiry, and stimulates the examination of different perspectives, thus enabling people to function effectively in a complex and changing world. General education tends to emphasize oral and written communication, critical analysis of information, knowledge and appreciation of diverse cultures, ways of knowing and human expression, knowledge of mathematical processes and natural sciences investigations, and ethics. General education courses are not intended to be developmental in nature. Each community college is responsible for clarifying, articulating, publicizing, and assessing its general education program.

21.4(2) College parallel or transfer.

a. This program shall offer courses that are the equivalent of the first two years of a baccalaureate program and may also include: such courses as may be necessary to develop skills that are prerequisite to other courses and objectives; and specialized courses required to provide career options within the college parallel or transfer program. College parallel or transfer programs are associate of arts and associate of science degree programs. General education courses in college parallel or transfer programs are required to be college transfer courses. A follow-up of students terminating shall be conducted to determine how well students have succeeded and which adjustments in the curriculum, if any, need to be made.

b. Courses of a developmental or remedial nature or prefreshman level shall not bear college transfer credit and shall be clearly identified in the college catalog. Developmental courses on the transcript shall be identifiable through the adoption of the community college common course numbering system.

21.4(3) Career and technical education. Instruction shall be offered in career and technical education programs in no less than five different occupational fields as defined by the department. College parallel or transfer courses may be offered as needed in career and technical education programs. Career and technical education programs, including associate of science-career option programs, must meet program approval requirements set by the state board of education. The director shall approve new career and technical education programs. Instruction shall be offered in career and technical education programs, ensuring that they are competency-based, contain all minimum competencies required by the department, articulate with local school districts' career and technical education programs, and comply with any applicable requirements in Iowa Code chapter 258. The occupational fields in which instruction is offered shall be determined by merged area and geographical area needs as identified by surveys in these areas. Occupational advisory committees may be used to assist in developing and maintaining instructional content, including leadership development.

21.4(4) Adult and continuing education. Adult education shall be offered and may include adult basic education, adult continuing and general education, college parallel or transfer, high school completion, supplementary and preparatory career education programs, and other programs and experiences as may be required to meet the needs of people in the merged area.

21.4(5) Community services. The community colleges shall provide a program of community services designed to meet the needs of persons residing in the merged area. The purpose of the community service program shall be to foster agricultural, business, cultural, industrial, recreational and social development in the area.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.5(260C) Library or learning resource center.

21.5(1) Facilities. Community college libraries or learning resource centers shall provide the facilities and resources needed to support the total educational program of the institution and shall show evidence that the facilities and the resources are being used effectively and efficiently. Adequate consideration shall be given to the seating, comfort, setting, and technology of the facility used to house the collection and learning resources.

21.5(2) Staffing. The library or learning resource center shall be adequately staffed with qualified professionals and skilled nonprofessional personnel.

21.5(3) Collection. The library and learning resource center materials collection of a community college shall be accessible and adequate in size and scope to serve effectively the number and variety of programs offered and the number of students enrolled, including distance and satellite sites. The library and learning resource center materials collection shall show evidence of having been selected by faculty as well as professional library or learning resource staff and shall be kept up-to-date through a planned program of acquisition and deletion. The library and learning resource center materials collection shall contain a range and number of print and nonprint materials and appropriate electronic information resources.

21.5(4) Expenditures. The budget of the library or learning resource center shall be appropriate for the programs and services offered by the institution. New programs and new curricula shall be reflected in library or learning resource center expenditures.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.6(260C) Student services. A program of student services shall be provided to meet the needs of students in the community college. The program of student services shall include, but not be limited to, the following functional areas:

1. Orientation to college and career opportunities and requirements.
2. Appraisal of individual potential.
3. Consultation with students about their plans, progress and problems.
4. Participation of students in activities that supplement classroom experiences.
5. Regulation to provide an optimal climate for social and academic development.
6. Services that facilitate community college attendance through a program of financial assistance, and facilitate transition to further education or employment.
7. Organization that provides for continuing articulation, evaluation and improvement of the student services program.
8. Campus safety and security as required by Iowa Code chapter 260C and the federal Clery Act, 20 U.S.C. Section 1092(f), 34 CFR Section 668.46.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.7(260C) Laboratories, equipment and supplies. Laboratories, equipment and supplies shall be comparable with those used in the occupations for which instruction is offered. Similarly, college parallel or transfer courses shall be supported in a manner comparable to those conditions which prevail in standard, regionally accredited colleges and universities in which students may wish to transfer college credits.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.8(260C) Physical plant. The site, buildings and equipment of the community college shall be well maintained and in good condition. At a minimum, a five-year ongoing, systematic maintenance and facilities plan approved by the local community college board shall be in evidence. The physical plant shall be adequate in size and properly equipped for the program offered. All remodeling of existing facilities shall comply with Iowa Code chapter 104A and the federal Americans With Disabilities Act, 42 U.S.C. Section 12101 et seq.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.9(260C) Nonreimbursable facilities. No facility intended primarily for events for which admission may be charged nor any facility specially designed for athletic or recreational activities, other than physical education, shall be constructed with state-appropriated funds.
[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.10(260C) Accreditation. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.11(260C) Community college accreditation process. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.12(260C) Standards for community colleges. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.13 to 21.19 Reserved.

The rules in this division are intended to implement Iowa Code chapter 260C and 2007 Iowa Acts, Senate File 601.

DIVISION II
COMMUNITY COLLEGE ENERGY APPROPRIATIONS

281—21.20 to 21.29 Reserved.

DIVISION III
INSTRUCTIONAL COURSE FOR DRINKING DRIVERS

281—21.30(321J) Purpose. The instructional course for drinking drivers is designed to inform the offender about drinking and driving and encourage the offender to assess the offender's own drinking and driving behavior in order to select practical alternatives.
[ARC 1433C, IAB 4/30/14, effective 6/4/14]

281—21.31(321J) Course.

21.31(1) A course provided in accordance with Division III of this chapter shall be offered on a regular basis at each community college or by a substance abuse treatment program licensed under Iowa Code chapter 125. However, a community college shall not be required to offer the course if a substance abuse treatment program licensed under Iowa Code chapter 125 offers the course within the merged area served by the community college. A course provided in accordance with Division III of this chapter may be offered at a state correctional facility listed in Iowa Code section 904.102.

21.31(2) The department of education shall maintain a listing of all providers of approved courses in the state and publish this listing on the department's Web site.

21.31(3) Individuals who reside outside the state of Iowa and who are required by the state of Iowa to take a course for drinking drivers shall have the opportunity to take the course in another state, provided:

a. The out-of-state course is comparable to those courses approved to be offered in the state of Iowa.

b. The course is delivered in a classroom setting and not online.

21.31(4) Enrollment in the course is not limited to persons ordered to enroll, attend, and successfully complete the course required under Iowa Code sections 321J.1 and 321J.17, subsection 2. Any person under the age of 18 who is required to attend the courses for violation of Iowa Code section 321J.2 or 321J.17 must attend a course offered by a substance abuse treatment program licensed under Iowa Code chapter 125.

21.31(5) An instructional course shall be approved by the department of education in consultation with the community colleges, substance abuse treatment programs licensed under Iowa Code chapter 125, the Iowa department of public health, and the Iowa department of corrections. The course shall be delivered in a classroom setting with at least 12 hours of instructional time delivered over a minimum of a two-day period. The course may be offered in blocks not to exceed 4 hours with a minimum of a 30-minute break between blocks. Each student in the class shall receive an individual workbook, and

workbooks shall not be reused. The course shall be taught by an instructor certified by the curriculum provider to teach the course. Each course of instruction shall establish the following:

- a. An understanding that alcohol-related problems could happen to anyone and that a person's drinking choices matter. The course illustrates common views of society that prevent people from taking drinking choices seriously. Research is presented to challenge common views with an understanding that alcohol problems are related to lifestyle choices.
- b. An understanding that specific low-risk choices will help reduce the risk of experiencing alcohol-related problems at any point in life. The course presents research-based, low-risk guidelines.
- c. Methods of providing support for making low-risk choices.
- d. An accurate description of the progression of drinking to the development of alcoholism to help people weigh the risk involved with high-risk drinking and to see how high-risk choices may jeopardize their lives and the lives of others.
- e. Opportunities to develop a specific plan of action to follow through with low-risk choices. A list of community resources is provided for ongoing support and treatment as needed.

[ARC 9901B, IAB 12/14/11, effective 1/18/12; ARC 1433C, IAB 4/30/14, effective 6/4/14]

281—21.32(321J) Tuition fee established.

21.32(1) Each person enrolled in an instructional course for drinking drivers shall pay to the community college or a substance abuse treatment program licensed under Iowa Code chapter 125 a tuition fee of \$85 for the approved 12-hour course, plus a reasonable book fee. The court may allow an offender to combine the required course with a program that incorporates jail time. Reasonable fees may be assessed for costs associated with lodging, meals, and security.

21.32(2) A person shall not be denied enrollment in a course by reason of a person's indigency. For court-ordered placement, the court shall determine a person's indigency. In all other instances, the community college, substance abuse treatment program licensed under Iowa Code chapter 125, or state correctional facility shall determine indigence upon application.

[ARC 1433C, IAB 4/30/14, effective 6/4/14]

281—21.33(321J) Administrative fee established.

21.33(1) *Students enrolled in Iowa.* Each person enrolled in Iowa in an instructional course for drinking drivers under this chapter shall be charged an administrative fee of \$10. This fee is in addition to tuition and shall be collected by the provider of the instructional course in conjunction with the tuition fee established under 281—21.32(321J). The administrative fee shall be forwarded to the department of education on a quarterly basis as prescribed by the department. If a student has been declared by the court as indigent, no administrative fee will be charged to that student.

21.33(2) *Students enrolled in another state.* Each person enrolled outside the state of Iowa in an instructional course for drinking drivers under this chapter shall be charged an administrative fee of \$25. This fee is in addition to tuition and shall be paid directly to the department of education by the student. Upon payment of the fee, the department of education shall review the educational component of the course taken by the student and shall inform the department of transportation whether the educational component is approved by the department of education.

[ARC 1433C, IAB 4/30/14, effective 6/4/14]

281—21.34(321J) Advisory committee. A drinking driver education advisory committee shall be established by the department of education to serve in an advisory capacity to the department of education in matters relevant to the instructional course for drinking drivers. Membership on this committee shall include representatives from agencies currently offering the instructional course for drinking drivers and may include other stakeholders.

[ARC 1433C, IAB 4/30/14, effective 6/4/14]

The rules in this division are intended to implement Iowa Code section 321J.22.

DIVISION IV
JOBS NOW CAPITALS ACCOUNT

281—21.35 to 21.44 Reserved.

DIVISION V
STATE COMMUNITY COLLEGE FUNDING PLAN

281—21.45(260C) Purpose. A distribution plan for general state financial aid to Iowa's community colleges is established for the fiscal year commencing July 1, 1999, and succeeding fiscal years. Funds appropriated by the general assembly to the department of education for general financial aid to community colleges shall be allocated to each community college in the manner defined in this chapter.

21.45(1) Distribution formula. Moneys appropriated by the general assembly from the general fund to the department for community college purposes for general state financial aid for a budget year shall be allocated to each community college by the department according to the provisions of Iowa Code section 260C.18C.

21.45(2) Each community college shall provide student and financial information in the manner and form as determined by the department and before the deadline announced by the department. If the community college fails to provide the student or financial information as required, the department shall estimate the full-time equivalent enrollment (FTEE) of that college that will be used in the state general aid distribution formula.

21.45(3) Each community college shall be required to hire an auditing firm to complete and submit the schedule of credit-hour and contact-hour enrollment and a letter certifying that specified department of education procedures were followed. These schedules will be used in calculating the college's FTEE utilized in the community college state general aid distribution formula.

This rule is intended to implement Iowa Code section 260C.18C.
[ARC 8646B, IAB 4/7/10, effective 5/12/10]

DIVISION VI
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281—21.46 to 21.56 Reserved.

DIVISION VII
QUALITY INSTRUCTIONAL CENTER INITIATIVE

281—21.57(260C) Purpose. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.58(260C) Definitions. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.59(260C) Eligibility requirements. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.60(260C) Timelines. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.61(260C) Evaluation and selection criteria. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.62(260C) Funding. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.63(260C) Annual report. Rescinded IAB 4/7/10, effective 5/12/10.

DIVISION VIII
PROGRAM AND ADMINISTRATIVE SHARING INITIATIVE
Rules 281—21.64(280A) to 21.71(280A), effective 12/20/91 were rescinded IAB 2/5/92, effective 1/7/92; these rules were readopted IAB 4/1/92, effective 5/6/92.

281—21.64(260C) Purpose. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.65(260C) Definitions. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.66(260C) Eligibility requirements. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.67(260C) Timelines. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.68(260C) Evaluation and selection criteria. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.69(260C) Funding. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.70(260C) Annual report. Rescinded IAB 4/7/10, effective 5/12/10.

281—21.71(260C) Combining merged areas—election. Rescinded IAB 4/7/10, effective 5/12/10.

DIVISION IX
APPRENTICESHIP PROGRAM

281—21.72(260C) Purpose. The purpose of the apprenticeship program is to provide individuals, at least 16 years of age, except where a higher minimum age standard is otherwise fixed by law, employment to learn a skilled trade or an occupation; and to authorize each community college to establish or contract for the establishment of apprenticeship programs for apprenticeable occupations.

281—21.73(260C) Definitions. For the purpose of Division IX, the following definitions shall apply:

“Apprentice” shall mean a worker at least 16 years of age, except where a higher minimum age standard is otherwise fixed by law, who is employed to learn a skilled trade or occupation under the standards of apprenticeship.

“Apprenticeable occupation” is a skilled trade which possesses all of the following characteristics:

1. It is customarily learned in a practical way through a structured, systematic program of on-the-job, supervised training.
2. It is clearly identified and commonly recognized throughout an industry.
3. It involves manual, mechanical or technical skills and knowledge which require a minimum of 2,000 hours of on-the-job work experience.
4. It requires related instruction to supplement on-the-job training.

“Apprenticeship agreement” shall mean a written agreement between an apprentice and the apprentice’s employer, or an apprenticeship committee acting as the agent for the employer(s). The agreement contains the terms and conditions of the employment and training of the apprentice.

“Apprenticeship committee” shall mean those persons designated by the sponsor to act for it in the administration of the program. A committee may be “joint,” i.e., composed of an equal number of representatives of the employer(s) and of the employees represented by a bona fide collective bargaining agent(s), and is established to conduct, operate, or administer an apprenticeship program and enter into apprenticeship agreements with apprentices. A committee may be “unilateral” or “nonjoint” and shall mean a program sponsor in which a bona fide collective bargaining agent is not a participant.

“Apprenticeship instructor” shall mean an instructor who delivers related and technical instruction in apprenticeship programs and who must meet the department’s requirements for career and technical instructors or be recognized as a subject matter expert. It is recommended that all apprenticeship instructors have training in teaching techniques and adult learning styles.

“Apprenticeship program” shall mean a plan containing all terms and conditions for the qualification, recruitment, selection, employment and training of apprentices, including such matters as required under 29 CFR Parts 29 and 30, including the requirement for a written apprenticeship agreement.

“Cancellation” shall mean the termination of the registration or approval status of a program at the request of the sponsor or termination of an apprenticeship agreement at the request of the apprentice.

“*Certification*” or “*certificate*” shall mean documentary evidence that at least one of the following has been met:

1. The Office of Apprenticeship has approved a set of National Guidelines for Apprenticeship Standards developed by a national committee or organization, joint or unilateral, or policy or guideline used by local affiliates, as conforming to the standards of apprenticeship set forth in 29 CFR Section 29.5;

2. A registration agency has established that an individual is eligible for probationary employment as an apprentice under a registered apprenticeship program.

3. A registration agency has registered an apprenticeship program as evidenced by a certificate of registration or other written indicia;

4. A registration agency has determined that an apprenticeship has successfully met the requirements to receive an interim credential; or

5. A registration agency has determined that an individual has successfully completed an apprenticeship.

“*Competency*” shall mean the attainment of manual or technical skill and knowledge as specified by an occupational standard.

“*Employer*” shall mean any person or organization employing an apprentice whether or not such person or organization is a party to an apprenticeship agreement with the apprentice.

“*Journeyworker*” shall mean a worker who has attained a level of skill and competency recognized within an industry as having mastered the skills and competencies required for the occupation.

“*Office of Apprenticeship*” shall mean the office designated by the Employment and Training Administration to administer the National Apprenticeship System or its successor organization.

“*Registration agency*” shall mean the Office of Apprenticeship.

“*Registration of an apprenticeship agreement*” shall mean the acceptance and recording of an apprenticeship agreement by the Office of Apprenticeship as evidence of the apprentice’s participation in a particular registered apprenticeship program.

“*Related instruction*” or “*related technical instruction*” shall mean an organized and systematic form of instruction designed to provide the apprentice with the core knowledge of the theoretical and technical subjects related to the apprentice’s occupation. Such instruction may be given in a classroom through occupational or industrial courses, by correspondence courses of equivalent value, by electronic media, or by other forms of self-study approved by the registration agency.

“*Sponsor*” shall mean any person, association, committee or organization operating an apprenticeship program and in whose name the program is (or is to be) registered or approved.

“*Supplemental instruction*” shall mean instruction in non-core-related requirements; for example, job site management, leadership, communications, first aid/CPR, field trips, and new technologies.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

281—21.74(260C) Apprenticeship programs. For an apprenticeship program to be offered by a community college or a local educational agency, the program must be approved by the U.S. Department of Labor, Office of Apprenticeship, and meet all requirements outlined in the National Apprenticeship Act, 29 U.S.C. Section 50, 29 CFR Parts 29 and 30.

[ARC 8646B, IAB 4/7/10, effective 5/12/10]

The rules in this division are intended to implement Iowa Code section 260C.44 and the National Apprenticeship Act, 29 U.S.C. Section 50, and 29 CFR Parts 29 and 30.

DIVISION X
MISCELLANEOUS PROVISIONS

281—21.75(260C,82GA,SF358) Used motor vehicle dealer education program. An applicant for a license from the department of transportation as a used motor vehicle dealer shall complete a minimum of eight hours of prelicensing education program courses pursuant to 2007 Iowa Acts, Senate File 358, prior to submitting the application. The education program courses are provided by community colleges or by the Iowa Independent Automobile Dealers Association in conjunction with a community college.

The fee for both the preclicensing education program courses and continuing education courses shall not exceed \$50 per contact hour of instruction, which shall include course materials and administrative costs.

This rule is intended to implement Iowa Code chapter 260C and 2007 Iowa Acts, Senate File 358.

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[◇] Two or more ARCs

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[Prior to 6/15/88, see Professional Teaching Practices Commission[640]]

[Prior to 5/16/90, see Professional Teaching Practices Commission[287]]

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282—12.1(272) Issuance of licenses, certificates, authorizations, and statements of professional recognition. All application and licensure fees are nonrefundable. The fee for the issuance of a license, certificate, statement of professional recognition, or authorization shall be \$85 unless otherwise specified below:

1. Class E emergency license shall be \$150.
2. Paraeducator certificate shall be \$40.
3. Behind-the-wheel authorization shall be \$40.

[ARC 9743B, IAB 9/7/11, effective 10/12/11; ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—12.2(272) Fees for the renewal or extension of licenses, certificates, statements of professional recognition, and authorizations. The fee for the renewal or extension of a license, certificate, statement of professional recognition, or authorization shall be \$85 unless otherwise specified below:

1. The renewal of the paraeducator certificate shall be \$40.
2. The renewal of the behind-the-wheel authorization shall be \$40.
3. A one-year extension for renewal of a coaching authorization shall be \$40.
4. A one-year extension of the initial license shall be \$25. This extension may be issued if the applicant needs one additional year to meet the experience requirement for the standard license, but has met Iowa teaching standards, pursuant to rule 282—20.4(272).

5. A \$25 fee for an extension of the initial administrator license, which may be issued instead of renewing the initial administrator license if the applicant verifies one of the criteria listed in 282—subrule 20.8(2).

[ARC 9743B, IAB 9/7/11, effective 10/12/11; ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—12.3(272) Evaluation fee. Each application from an out-of-state institution for initial licensure shall include, in addition to the basic fee for the issuance of a license, a one-time nonrefundable \$60 evaluation fee. Each application or request for a statement of professional recognition shall include a one-time nonrefundable \$60 evaluation fee.

282—12.4(272) Adding endorsements.

12.4(1) Fee for each added endorsement. The fee for each additional endorsement to a license following the issuance of the initial license and endorsement(s) shall be \$50. The fee for each additional endorsement added to a paraeducator certificate shall be \$25.

12.4(2) Fee for transcript review. Applicants may ask the board of educational examiners to analyze transcripts if the applicant believes all requirements have been met. Applicants who request board of educational examiners transcript analysis shall be assessed a \$60 transcript evaluation fee for each new endorsement requested. This fee shall be in addition to the fee for adding the endorsement.

[ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—12.5(272) Duplicate licenses, authorizations, and statements of professional recognition. The fee for the issuance of a duplicate practitioner's license, certificate, statement of professional recognition, or authorization shall be \$15.

[ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—12.6(272) Late fees.

12.6(1) An additional fee of \$25 per calendar month, not to exceed \$150, shall be imposed if an application for renewal or conversion of a Class A, B, or E license or a statement of professional recognition (SPR) is submitted after the date of expiration of a practitioner's license. Waiver of the late fee will be granted only upon a showing of extraordinary circumstances rendering imposition of the fee unreasonable.

12.6(2) Failure to hold an endorsement. An additional fee of \$25 per calendar month, not to exceed \$150, shall be imposed if the practitioner holds a valid Iowa license, but does not hold an endorsement for the type of service for which the practitioner is employed.

12.6(3) Failure to hold valid Iowa license or authorization. An additional fee of \$100 per calendar month, not to exceed \$500, shall be imposed if the practitioner does not hold a valid Iowa license or authorization. The fee will begin to be assessed on the first day of the school year for which the practitioner is employed until the practitioner submits a completed application packet for the appropriate license. The penalty will enforce Iowa Code section 272.7. Waiver of the fee will be granted only upon a showing of extraordinary circumstances rendering imposition of the fee unreasonable.

[ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—12.7(272) Fees nonrefundable. All fees as set out in this chapter are nonrefundable.

282—12.8(272) Portfolio review and evaluation fees. The fee for review and evaluation of an applicant portfolio is set as follows:

12.8(1) For the professional education core, the portfolio review and evaluation fee shall be \$500.

12.8(2) For content endorsement, the portfolio review and evaluation fee shall be \$250.

[ARC 8606B, IAB 3/10/10, effective 4/14/10]

282—12.9(272) Retention of incomplete applications.

12.9(1) *Timeline for complete application materials to be submitted.* Upon receipt of an incomplete application, the executive director will send a letter of deficiencies to the applicant stipulating that complete application materials must be submitted to the board office within 45 days of the date the letter is received. If the materials are not received within that timeline, the application process will be closed. If the applicant submits information after the 45-day deadline, the application process requires submission of a complete set of application materials and fees, including late fees if applicable, for practicing with an expired license, without the proper endorsement, or without an Iowa board-issued license.

12.9(2) *Background check.* The background check fee will be valid for one year. If a license is not issued within one year of a completed background check, the background check shall be considered void.

12.9(3) *Timeline for audited online renewals.* Upon receipt of notification that the online renewal application has been audited, the applicant shall have 30 days to submit the official transcripts and mandatory reporter verification to the board office. If the materials are not received within that timeline, the applicant will be notified that the application process is closed. If the applicant submits information after the 30-day deadline, the application process requires submission of a complete set of application materials and fees. If the license expires during the 30-day deadline and the applicant is teaching, the school district will be notified that the applicant's license is expired and the individual shall not continue teaching until the complete application materials are submitted to the board office.

12.9(4) *Request for additional time.* If the applicant is not able to submit the application materials by the deadline, the applicant may contact the executive director with a request for additional time. The applicant must submit verification as to the need for the additional time. The executive director will review the request and provide a written decision either approving or denying the request.

[ARC 9386B, IAB 2/23/11, effective 3/30/11; ARC 2017C, IAB 6/10/15, effective 7/15/15]

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]

[Filed ARC 8606B (Notice ARC 8251B, IAB 11/4/09), IAB 3/10/10, effective 4/14/10]

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[Filed ARC 2017C (Notice ARC 1919C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]

CHAPTER 13
ISSUANCE OF TEACHER LICENSES AND ENDORSEMENTS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

282—13.1(272) All applicants desiring Iowa licensure. Licenses are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

13.1(1) *National criminal history background check.* An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

13.1(2) *Iowa division of criminal investigation background check.* An Iowa division of criminal investigation background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

13.1(3) *Temporary permits.* The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check. The temporary permit shall serve as evidence of the applicant's authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

[ARC 0563C, IAB 1/23/13, effective 1/1/13]

282—13.2(272) Applicants from recognized Iowa institutions. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.3(272) Applicants from non-Iowa institutions. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.4(272) Applicants from foreign institutions. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.5(272) Teacher licenses. A license may be issued to applicants who fulfill the general requirements set out in subrule 13.5(1) and the specific requirements set out for each license.

13.5(1) *General requirements.* The applicant shall:

- a. Have a baccalaureate degree from a regionally accredited institution.
- b. Have completed a state-approved teacher education program.
- c. Have completed the teacher preparation coursework set forth in 281—subrules 79.15(2) to 79.15(5).
- d. Have completed student teaching in the subject area and grade level endorsement desired.
- e. Have completed the requirements for one of the basic teaching endorsements.
- f. Provide a recommendation for the specific license and endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed.

13.5(2) *Applicants from non-Iowa institutions.*

a. Definitions.

“*Nontraditional*” means any method of teacher preparation that falls outside the traditional method of preparing teachers, that provides at least a one- or two-year sequenced program of instruction taught at regionally accredited and state-approved colleges or universities, that includes commonly recognized pedagogy classes being taught for course credit, and that requires a student teaching component.

“*Proficiency*,” for the purposes of paragraph 13.5(2) “e,” means that an applicant has passed all parts of the standard.

“*Recognized non-Iowa teacher preparation institution*” means an institution that is state-approved and is accredited by the regional accrediting agency for the territory in which the institution is located.

b. In addition to the requirements set forth in subrule 13.5(1), applicants from non-Iowa institutions:

(1) Shall submit a copy of a valid or expired regular teaching certificate or license exclusive of a temporary, emergency or substitute license or certificate.

(2) Shall provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education if the teacher preparation program was completed on or after January 1, 2013. If the teacher preparation program was completed prior to January 1, 2013, the applicant must provide verification of successfully passing the mandated assessment(s) in the state in which the applicant is currently licensed (or verify highly qualified status) or must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education.

(3) Shall provide an official institutional transcript(s) to be analyzed for the requirements necessary for Iowa licensure. An applicant must have completed at least 75 percent of the coursework as outlined in 281—subrules 79.15(2) to 79.15(5) and an endorsement requirement through a two- or four-year institution in order for the endorsement to be included on the license. An applicant who has not completed at least 75 percent of the coursework for at least one of the basic Iowa teaching endorsements completed will not be issued a license.

(4) Shall demonstrate recency of experience by providing verification of either one year of teaching experience or six semester hours of college credit during the five-year period immediately preceding the date of application.

(5) Shall not be subject to any pending disciplinary proceedings in any state or country.

(6) Shall comply with all requirements with regard to application processes and payment of licensure fees.

c. If through a transcript analysis, the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) or one of the basic teaching endorsement requirements for Iowa is not met, the applicant may be eligible for the equivalent Iowa endorsement areas, as designated by the Iowa board of educational examiners, based on current and valid National Board Certification.

d. If the teacher preparation program was considered nontraditional, candidates will be asked to verify the following:

(1) That the program was for secondary education;

(2) A cumulative grade point average of 2.50 on a 4.0 scale from a regionally accredited institution; and

(3) The completion of a student teaching or internship experience or three years of teaching experience.

e. If the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) cannot be reviewed through a traditional transcript evaluation, a portfolio review and evaluation process may be utilized.

(1) An applicant must demonstrate proficiency in a minimum of at least 75 percent of the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5).

(2) An applicant must meet with the board of educational examiners to answer any of the board's questions concerning the portfolio.

13.5(3) *Applicants from foreign institutions.* An applicant for initial licensure whose preparation was completed in a foreign institution must obtain a course-by-course credential evaluation report completed by one of the board-approved credential evaluation services and then file this report with the Iowa board of educational examiners for a determination of eligibility for licensure. After receiving the notification of eligibility by the Iowa board of educational examiners, the applicant must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education.

[ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.6(272) Specific requirements for an initial license. An initial license valid for two years may be issued to an applicant who meets the general requirements set forth in rule 282—13.5(272).

[ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.7(272) Specific requirements for a standard license. A standard license valid for five years may be issued to an applicant who:

1. Meets the general requirements set forth in rule 282—13.5(272), and
2. Shows evidence of successful completion of a state-approved mentoring and induction program by meeting the Iowa teaching standards as determined by a comprehensive evaluation and two years' successful teaching experience. In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful teaching experience in an Iowa nonpublic school or three years' successful teaching experience in an out-of-state K-12 educational setting.

[ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.8(272) Specific requirements for a master educator's license. A master educator's license is valid for five years and may be issued to an applicant who:

1. Is the holder of or is eligible for a standard license as set out in rule 282—13.7(272), and
2. Verifies five years of successful teaching experience, and
3. Completes one of the following options:
 - Master's degree from a regionally accredited college or university in a recognized endorsement area, or
 - Master's degree from a regionally accredited college or university in curriculum, effective teaching, or a similar degree program which has a focus on school curriculum or instruction.

[ARC 1168C, IAB 11/13/13, effective 12/18/13]

282—13.9(272) Teacher intern license.

13.9(1) Authorization. The teacher intern is authorized to teach in grades 7 to 12.

13.9(2) Term. The term of the teacher intern license will be one school year. This license is nonrenewable.

13.9(3) Teacher intern requirements. A teacher intern license may be issued to an applicant who has been recommended by an institution with a state-approved intern program and who has met the background check requirements set forth in rule 282—13.1(272).

13.9(4) Requirements to convert the teacher intern license to the initial license. An initial license shall be issued upon application provided that the teacher intern has met the requirements as verified by the recommendation from the state-approved program.

13.9(5) Requirements to extend the teacher intern license if the teacher intern does not complete all of the education coursework during the term of the teacher intern license.

a. A one-year extension of the teacher intern license may be issued upon application provided that the teacher intern has met both of the following requirements:

- (1) Successful completion of one year of teaching experience during the teacher internship.
- (2) Verification by the recommending official at the approved teacher intern program that the teacher intern has not completed all of the coursework required for the initial license.

b. Only one year of teaching experience during the term of the teacher intern license or the extension of a teacher intern license may be used to convert the teacher intern license to a standard teaching license.

[ARC 8688B, IAB 4/7/10, effective 5/12/10; ARC 9925B, IAB 12/14/11, effective 1/18/12; ARC 0698C, IAB 5/1/13, effective 6/5/13; ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 1374C, IAB 3/19/14, effective 4/23/14; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.10(272) Specific requirements for a Class A extension license. A nonrenewable Class A extension license valid for one year may be issued to an individual under one of the following conditions:

13.10(1) *Based on an expired Iowa certificate or license, exclusive of a Class A extension or Class B license.*

a. The holder of an expired license, exclusive of a Class A extension or Class B license, shall be eligible to receive a Class A extension license upon application. This license shall be endorsed for the type of service authorized by the expired license on which it is based.

b. The holder of an expired license who is currently under contract with an Iowa educational unit (area education agency/local education agency/local school district) and who does not meet the renewal requirements for the license held shall be required to secure the signature of the superintendent or designee before the license will be issued.

13.10(2) *Based on a mentoring and induction program.* An applicant may be eligible for a Class A extension license if the school district, after conducting a comprehensive evaluation, recommends and verifies that the applicant shall participate in the mentoring program for a third year. No further extensions are available for this type of Class A extension license.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 8134B, IAB 9/9/09, effective 10/14/09; ARC 8957B, IAB 7/28/10, effective 9/1/10; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.11(272) Specific requirements for a Class B license. A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

13.11(1) *Endorsement in progress.* The individual has a valid initial, standard, master educator, permanent professional, Class A extension, exchange, or professional service license and one or more endorsements but is seeking to obtain some other endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement. A Class B license may not be issued for the driver's education endorsement.

13.11(2) *Program of study for special education endorsement.* The college or university must outline the program of study necessary to meet the special education endorsement requirements. This program of study must be attached to the application.

13.11(3) *Request for executive director decision.* If the minimum content requirements have not been met for the Class B license, a one-year executive director decision license may be issued if requested by the school district and if the school district can demonstrate that a candidate with the proper endorsement was not found after a diligent search. The executive director decision license may not be renewed and will expire on June 30 of the fiscal year in which it was issued.

13.11(4) *Expiration.* The Class B license will expire on June 30 of the fiscal year in which it was issued plus one year.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 8133B, IAB 9/9/09, effective 10/14/09; ARC 9207B, IAB 11/3/10, effective 12/8/10; ARC 9573B, IAB 6/29/11, effective 8/3/11; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.12(272) Specific requirements for a Class C license. Rescinded IAB 7/29/09, effective 9/2/09.

282—13.13(272) Specific requirements for a Class D occupational license. Rescinded IAB 7/29/09, effective 9/2/09.

282—13.14(272) Specific requirements for a Class E emergency extension license. A nonrenewable license valid for one year may be issued to an individual as follows:

13.14(1) *Expired license.* Based on an expired Class A or Class B license, the holder of the expired license shall be eligible to receive a Class E emergency extension license upon application and submission of all required materials.

13.14(2) *Application.* The application process will require transcripts of coursework completed during the term of the expired license, a program of study indicating the coursework necessary to obtain full licensure, and registration for coursework to be completed during the term of the Class E emergency extension license. The Class E emergency extension license will be denied if the applicant

has not completed any coursework during the term of the Class A or Class B license unless extenuating circumstances are verified.

[ARC 7987B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.15(272) Specific requirements for a Class G license. A nonrenewable Class G license valid for one year may be issued to an individual who must complete a school counseling practicum or internship in an approved program in preparation for the professional school counselor endorsement. The Class G license may be issued under the following limited conditions:

1. Verification of a baccalaureate degree from a regionally accredited institution.
2. Verification from the institution that the individual is admitted and enrolled in a school counseling program.
3. Verification that the individual has completed the coursework and competencies required prior to the practicum or internship.
4. Written documentation of the requirements listed in “1” to “3” above, provided by the official at the institution where the individual is completing the approved school counseling program and forwarded to the Iowa board of educational examiners with the application form for licensure.

[ARC 1328C, IAB 2/19/14, effective 3/26/14]

282—13.16(272) Specific requirements for a substitute teacher’s license.

13.16(1) Substitute teacher requirements. A substitute teacher’s license may be issued to an individual who provides verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education if the teacher preparation program was completed on or after January 1, 2013, and who:

- a. Has completed a traditional teacher preparation program and been the holder of, or presently holds, or is eligible to hold, a license in Iowa; or
- b. Holds a valid or expired teaching certificate based on a nontraditional teacher preparation program, is able to verify three years of teaching experience, and provides passing scores on tests mandated by the state that issued the certificate. The license issued will contain a disclaimer stating that the holder of this license may not be eligible for full Iowa teaching licensure.

13.16(2) Validity. A substitute license is valid for five years and for not more than 90 days of teaching in one assignment during any one school year. A school district administrator may file a written request with the board for an extension of the 90-day limit in one assignment on the basis of documented need and benefit to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

13.16(3) Authorization. The holder of a substitute license is authorized to substitute teach in any school system in any position in which a regularly licensed teacher is employed except in the driver’s education classroom. In addition to the authority inherent in the initial, standard, master educator, professional administrator, regional exchange, and permanent professional licenses and the endorsement(s) held, the holder of one of these regular licenses may substitute on the same basis as the holder of a substitute license while the regular license is in effect. The executive director may grant permission for a substitute to serve outside of a substitute’s regular authority under unique circumstances.

[ARC 9205B, IAB 11/3/10, effective 12/8/10; ARC 9206B, IAB 11/3/10, effective 12/8/10; ARC 0605C, IAB 2/20/13, effective 3/27/13; ARC 1324C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.17(272) Specific requirements for exchange licenses.

13.17(1) Teacher exchange license.

a. For an applicant applying under 13.5(2), a one-year nonrenewable exchange license may be issued to the applicant under any of the following conditions:

- (1) The applicant has met the minimum coursework requirements for licensure but has some coursework deficiencies. Any coursework deficiencies must be completed for college credit through a regionally accredited institution, with the exception of human relations which may be taken for licensure renewal credit through an approved provider.

(2) The applicant submits verification that the applicant has applied for and will receive the applicant's first teaching license and is waiting for the processing or printing of a valid and current out-of-state license. The lack of a valid and current out-of-state license will be listed as a deficiency.

(3) The applicant has not met the requirement for recency set forth in 13.5(2) "b"(4).

b. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

13.17(2) *International teacher exchange license.*

a. A nonrenewable international exchange license may be issued to an applicant under the following conditions:

(1) The applicant has completed a teacher education program in another country; and

(2) The applicant is a participant in a teacher exchange program administered through the Iowa department of education, the U.S. Department of Education, or the U.S. Department of State.

b. Each exchange license shall be limited to the area(s) and level(s) of instruction as determined by an analysis of the application and the credential evaluation report.

c. This license shall not exceed one year unless the applicant can verify continued participation in the exchange program beyond one year.

d. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

13.17(3) *Military exchange license.*

a. Definitions.

"*Military service*" means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

"*Veteran*" means an individual who meets the definition of "veteran" in Iowa Code section 35.1(2).

b. Spouses of active duty military service members applying under 13.5(2). A three-year nonrenewable military exchange license may be issued to the applicant under the following conditions:

(1) The applicant has completed a traditional teacher preparation program at a regionally accredited and state-approved two- or four-year college.

(2) The applicant is the holder of a valid and current or an expired teaching license from another state.

(3) The applicant provides verification of the applicant's connection to or the applicant's spouse's connection to the military by providing a copy of current military orders with either a marriage license or a copy of a military ID card for the applicant's spouse.

(4) This license may be converted to a one-year regional exchange license upon application and payment of fees.

c. Veterans or their spouses applying under 13.5(2). A three-year military exchange license may be issued to an applicant who meets the requirements of 13.17(3) "b"(1) and (2). A veteran must provide a copy of the veteran's DD 214. A spouse must provide a copy of the veteran spouse's DD 214 and the couple's marriage license.

d. Spouses of active duty military service veterans, or veterans' spouses applying under 13.5(2). If the applicant has completed a nontraditional teacher preparation program but is not eligible for a teaching license, the applicant will be issued a substitute license, and the initial review for the portfolio review process will be completed by board staff. An applicant must provide verification of connection to the military outlined in 13.17(3) "b"(3) or 13.17(3) "c."

e. Military education, training, and service credit. An applicant for the military exchange license may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting documentation to the board of educational examiners. The applicant shall identify the experience or educational requirement to which the credit would be applied if granted. The board of educational examiners shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational requirement for licensure.

f. Fees. Fees for the background check, evaluation and license issued pursuant to 13.17(3) will be limited to the fee outlined in rule 282—12.1(272) for the issuance of a license.

[ARC 8138B, IAB 9/9/09, effective 10/14/09; ARC 8604B, IAB 3/10/10, effective 4/14/10; ARC 9072B, IAB 9/8/10, effective 10/13/10; ARC 9840B, IAB 11/2/11, effective 12/7/11; ARC 0563C, IAB 1/23/13, effective 1/1/13; ARC 0868C, IAB 7/24/13, effective 8/28/13; ARC 1166C, IAB 11/13/13, effective 12/18/13; ARC 1323C, IAB 2/19/14, effective 3/26/14; ARC 1454C, IAB 5/14/14, effective 6/18/14; ARC 1878C, IAB 2/18/15, effective 3/25/15; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.18(272) General requirements for an original teaching subject area endorsement. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.19(272) NCATE-accredited programs. Rescinded IAB 6/17/09, effective 7/22/09.

282—13.20 Reserved.

282—13.21(272) Human relations requirements for practitioner licensure. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.22(272) Development of human relations components. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—13.23 to 13.25 Reserved.

282—13.26(272) Requirements for elementary endorsements.

13.26(1) Teacher—prekindergarten-kindergarten.

a. Authorization. The holder of this endorsement is authorized to teach at the prekindergarten-kindergarten level.

b. Content.

(1) Human growth and development: infancy and early childhood, unless completed as part of the professional education core.

(2) Curriculum development and methodology for young children.

(3) Child-family-school-community relationships (community agencies).

(4) Guidance of young children three to six years of age.

(5) Organization of prekindergarten-kindergarten programs.

(6) Child and family nutrition.

(7) Language development and learning.

(8) Kindergarten: programs and curriculum development.

13.26(2) Teacher—prekindergarten through grade three.

a. Authorization. The holder of this endorsement is authorized to teach children from birth through grade three.

b. Content.

(1) Child growth and development with emphasis on cognitive, language, physical, social, and emotional development, both typical and atypical, for infants and toddlers, preprimary, and primary school children (grades one through three), unless combined as part of the professional education core.

(2) Historical, philosophical, and social foundations of early childhood education.

(3) Developmentally appropriate curriculum with emphasis on integrated multicultural and nonsexist content including language, mathematics, science, social studies, health, safety, nutrition, visual and expressive arts, social skills, higher-thinking skills, and developmentally appropriate methodology, including adaptations for individual needs, for infants and toddlers, preprimary, and primary school children.

(4) Characteristics of play and creativity, and their contributions to the cognitive, language, physical, social and emotional development and learning of infants and toddlers, preprimary, and primary school children.

(5) Classroom organization and individual interactions to create positive learning environments for infants and toddlers, preprimary, and primary school children based on child development theory emphasizing guidance techniques.

(6) Observation and application of developmentally appropriate assessments for infants and toddlers, preprimary, and primary school children recognizing, referring, and making adaptations for children who are at risk or who have exceptional educational needs and talents.

(7) Home-school-community relationships and interactions designed to promote and support parent, family and community involvement, and interagency collaboration.

(8) Family systems, cultural diversity, and factors which place families at risk.

(9) Child and family health and nutrition.

(10) Advocacy, legislation, and public policy as they affect children and families.

(11) Administration of child care programs to include staff and program development and supervision and evaluation of support staff.

(12) Pre-student teaching field experience with three age levels in infant and toddler, preprimary, and primary programs, with no less than 100 clock hours, and in different settings, such as rural and urban, socioeconomic status, cultural diversity, program types, and program sponsorship.

(13) Student teaching experiences with two different age levels, one before kindergarten and one from kindergarten through grade three.

13.26(3) Teacher—prekindergarten through grade three, including special education.

a. Authorization. The holder of this endorsement is authorized to teach children from birth through grade three.

b. Content.

(1) Child growth and development.

1. Understand the nature of child growth and development for infants and toddlers (birth through age 2), preprimary (age 3 through age 5) and primary school children (age 6 through age 8), both typical and atypical, in areas of cognition, language development, physical motor, social-emotional, aesthetics, and adaptive behavior.

2. Understand individual differences in development and learning including risk factors, developmental variations and developmental patterns of specific disabilities and special abilities.

3. Recognize that children are best understood in the contexts of family, culture and society and that cultural and linguistic diversity influences development and learning.

(2) Developmentally appropriate learning environment and curriculum implementation.

1. Establish learning environments with social support, from the teacher and from other students, for all children to meet their optimal potential, with a climate characterized by mutual respect, encouraging and valuing the efforts of all regardless of proficiency.

2. Appropriately use informal and formal assessment to monitor development of children and to plan and evaluate curriculum and teaching practices to meet individual needs of children and families.

3. Plan, implement, and continuously evaluate developmentally and individually appropriate curriculum goals, content, and teaching practices for infants, toddlers, preprimary and primary children based on the needs and interests of individual children, their families and community.

4. Use both child-initiated and teacher-directed instructional methods, including strategies such as small and large group projects, unstructured and structured play, systematic instruction, group discussion and cooperative decision making.

5. Develop and implement integrated learning experiences for home-, center- and school-based environments for infants, toddlers, preprimary and primary children.

6. Develop and implement integrated learning experiences that facilitate cognition, communication, social and physical development of infants and toddlers within the context of parent-child and caregiver-child relationships.

7. Develop and implement learning experiences for preprimary and primary children with focus on multicultural and nonsexist content that includes development of responsibility, aesthetic and artistic development, physical development and well-being, cognitive development, and emotional and social development.

8. Develop and implement learning experiences for infants, toddlers, preprimary, and primary children with a focus on language, mathematics, science, social studies, visual and expressive arts, social skills, higher-thinking skills, and developmentally appropriate methodology.

9. Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs.

10. Adapt materials, equipment, the environment, programs and use of human resources to meet social, cognitive, physical motor, communication, and medical needs of children and diverse learning needs.

(3) Health, safety and nutrition.

1. Design and implement physically and psychologically safe and healthy indoor and outdoor environments to promote development and learning.

2. Promote nutritional practices that support cognitive, social, cultural and physical development of young children.

3. Implement appropriate appraisal and management of health concerns of young children including procedures for children with special health care needs.

4. Recognize signs of emotional distress, physical and mental abuse and neglect in young children and understand mandatory reporting procedures.

5. Demonstrate proficiency in infant-child cardiopulmonary resuscitation, emergency procedures and first aid.

(4) Family and community collaboration.

1. Apply theories and knowledge of dynamic roles and relationships within and between families, schools, and communities.

2. Assist families in identifying resources, priorities, and concerns in relation to the child's development.

3. Link families, based on identified needs, priorities and concerns, with a variety of resources.

4. Use communication, problem-solving and help-giving skills in collaboration with families and other professionals to support the development, learning and well-being of young children.

5. Participate as an effective member of a team with other professionals and families to develop and implement learning plans and environments for young children.

(5) Professionalism.

1. Understand legislation and public policy that affect all young children, with and without disabilities, and their families.

2. Understand legal aspects, historical, philosophical, and social foundations of early childhood education and special education.

3. Understand principles of administration, organization and operation of programs for children from birth to age 8 and their families, including staff and program development, supervision and evaluation of staff, and continuing improvement of programs and services.

4. Identify current trends and issues of the profession to inform and improve practices and advocate for quality programs for young children and their families.

5. Adhere to professional and ethical codes.

6. Engage in reflective inquiry and demonstration of professional self-knowledge.

(6) Pre-student teaching field experiences. Complete 100 clock hours of pre-student teaching field experience with three age levels in infant and toddler, preprimary, and primary programs and in different settings, such as rural and urban, encompassing differing socioeconomic status, ability levels, cultural and linguistic diversity and program types and sponsorship.

(7) Student teaching. Complete a supervised student teaching experience of a total of at least 12 weeks in at least two different classrooms which include children with and without disabilities in two of three age levels: infant and toddler, preprimary, and primary.

13.26(4) Teacher—elementary classroom. These requirements will sunset on August 31, 2015.

a. *Authorization.* The holder of this endorsement is authorized to teach in kindergarten and grades one through six.

b. *Content.*

- (1) Child growth and development with emphasis on the emotional, physical and mental characteristics of elementary age children, unless completed as part of the professional education core.
- (2) Methods and materials of teaching elementary language arts.
- (3) Methods and materials of teaching elementary reading.
- (4) Elementary curriculum (methods and materials).
- (5) Methods and materials of teaching elementary mathematics.
- (6) Methods and materials of teaching elementary science.
- (7) Children's literature.
- (8) Methods and materials of teaching elementary social studies.
- (9) Methods and materials in two of the following areas:
 1. Methods and materials of teaching elementary health.
 2. Methods and materials of teaching elementary physical education.
 3. Methods and materials of teaching elementary art.
 4. Methods and materials of teaching elementary music.
- (10) Pre-student teaching field experience in at least two different grades.
- (11) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.

13.26(5) Teacher—elementary classroom. Effective September 1, 2015, the following requirements apply to persons who wish to teach in the elementary classroom:

a. Authorization. The holder of this endorsement is authorized to teach in kindergarten and grades one through six.

b. Content.

- (1) Child growth and development with emphasis on the emotional, physical and mental characteristics of elementary age children, unless completed as part of the professional education core.
- (2) At least 9 semester hours in literacy which must include:
 1. Content:
 - Children's literature;
 - Oral and written communication skills for the twenty-first century.
 2. Methods:
 - Assessment, diagnosis and evaluation of student learning in literacy;
 - Integration of the language arts (to include reading, writing, speaking, viewing, and listening);
 - Integration of technology in teaching and student learning in literacy;
 - Current best-practice, research-based approaches of literacy instruction;
 - Classroom management as it applies to literacy methods;
 - Pre-student teaching clinical experience in teaching literacy.
- (3) At least 9 semester hours in mathematics which must include:
 1. Content:
 - Numbers and operations;
 - Algebra/number patterns;
 - Geometry;
 - Measurement;
 - Data analysis/probability.
 2. Methods:
 - Assessment, diagnosis and evaluation of student learning in mathematics;
 - Current best-practice, research-based instructional methods in mathematical processes (to include problem solving; reasoning; communication; the ability to recognize, make and apply connections; integration of manipulatives; the ability to construct and to apply multiple connected representations; and the application of content to real world experiences);
 - Integration of technology in teaching and student learning in mathematics;
 - Classroom management as it applies to mathematics methods;
 - Pre-student teaching clinical experience in teaching mathematics.
- (4) At least 9 semester hours in social sciences which must include:

1. Content:
 - History;
 - Geography;
 - Political science/civic literacy;
 - Economics;
 - Behavioral sciences.
 2. Methods:
 - Current best-practice, research-based approaches to the teaching and learning of social sciences;
 - Integration of technology in teaching and student learning in social sciences;
 - Classroom management as it applies to social science methods.
 - (5) At least 9 semester hours in science which must include:
 1. Content:
 - Physical science;
 - Earth/space science;
 - Life science.
 2. Methods:
 - Current best-practice, research-based methods of inquiry-based teaching and learning of science;
 - Integration of technology in teaching and student learning in science;
 - Classroom management as it applies to science methods.
 - (6) At least 3 semester hours to include all of the following:
 1. Methods of teaching elementary physical education, health, and wellness;
 2. Methods of teaching visual arts for the elementary classroom;
 3. Methods of teaching performance arts for the elementary classroom.
 - (7) Pre-student teaching field experience in at least two different grade levels to include one primary and one intermediate placement.
 - (8) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.
- [ARC 8400B, IAB 12/16/09, effective 1/20/10; ARC 8401B, IAB 12/16/09, effective 1/20/10; ARC 8402B, IAB 12/16/09, effective 1/20/10; ARC 8607B, IAB 3/10/10, effective 4/14/10; ARC 0446C, IAB 11/14/12, effective 12/19/12; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.27(272) Requirements for middle school endorsements.

13.27(1) Authorization. The holder of this endorsement is authorized to teach in the two concentration areas in which the specific requirements have been completed as well as in other subject areas in grades five through eight which are not the core content areas. The holder is not authorized to teach art, industrial arts, music, reading, physical education, talented and gifted, English as a second language, and special education.

13.27(2) Program requirements.

a. Be the holder of a currently valid Iowa teacher's license with either the general elementary endorsement or one of the subject matter secondary level endorsements set out in rule 282—13.28(272).

b. A minimum of 9 semester hours of required coursework in the following:

(1) Coursework in the growth and development of the middle school age child, specifically addressing the social, emotional, physical and cognitive characteristics and needs of middle school age children in addition to related studies completed as part of the professional education core.

(2) Coursework in middle school design, curriculum, instruction, and assessment including, but not limited to, interdisciplinary instruction, teaming, and differentiated instruction in addition to related studies completed as part of the professional education core.

(3) Coursework to prepare middle school teachers in literacy (reading, writing, listening and speaking) strategies for students in grades five through eight and in methods to include these strategies throughout the curriculum.

c. Thirty hours of middle school field experiences included in the coursework requirements listed in 13.27(2) "b" (1) to (3).

13.27(3) Concentration areas. To obtain this endorsement, the applicant must complete the coursework requirements in two of the following content areas:

a. Social studies concentration. The social studies concentration requires 12 semester hours of coursework in social studies to include coursework in United States history, world history, government and geography.

b. Mathematics concentration. The mathematics concentration requires 12 semester hours in mathematics to include coursework in algebra.

c. Science concentration. The science concentration requires 12 semester hours in science to include coursework in life science, earth science, and physical science.

d. Language arts concentration. The language arts concentration requires 12 semester hours in language arts to include coursework in composition, language usage, speech, young adult literature, and literature across cultures.

[ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.28(272) Minimum content requirements for teaching endorsements.

13.28(1) Agriculture. 5-12. Completion of 24 semester credit hours in agriculture and agriculture education to include:

a. Foundations of vocational and career education.

b. Planning and implementing courses and curriculum.

c. Methods and techniques of instruction to include evaluation of programs and students.

d. Coordination of cooperative education programs.

e. Coursework in each of the following areas and at least three semester credit hours in five of the following areas:

(1) Agribusiness systems.

(2) Power, structural, and technical systems.

(3) Plant systems.

(4) Animal systems.

(5) Natural resources systems.

(6) Environmental service systems.

(7) Food products and processing systems.

13.28(2) Art. K-8 or 5-12. Completion of 24 semester hours in art to include coursework in art history, studio art, and two- and three-dimensional art.

13.28(3) Business—all. 5-12. Completion of 30 semester hours in business to include 6 semester hours in accounting, 3 semester hours in business law to include contract law, 3 semester hours in computer and technical applications in business, 6 semester hours in marketing to include consumer studies, 3 semester hours in management, 6 semester hours in economics, and 3 semester hours in business communications to include formatting, language usage, and oral presentation. Coursework in entrepreneurship and in financial literacy may be a part of, or in addition to, the coursework listed above.

13.28(4) Driver education. 5-12. Completion of 9 semester hours in driver education to include coursework in accident prevention that includes drug and alcohol abuse; vehicle safety; and behind-the-wheel driving.

13.28(5) English/language arts.

a. K-8. Completion of 24 semester hours in English and language arts to include coursework in oral communication, written communication, language development, reading, children's literature, creative drama or oral interpretation of literature, and American literature.

b. 5-12. Completion of 24 semester hours in English to include coursework in oral communication, written communication, language development, reading, American literature, English literature and adolescent literature.

13.28(6) Language arts. 5-12. Completion of 40 semester hours in language arts to include coursework in the following areas:

a. Written communication.

(1) Develops a wide range of strategies and appropriately uses writing process elements (e.g., brainstorming, free-writing, first draft, group response, continued drafting, editing, and self-reflection) to communicate with different audiences for a variety of purposes.

(2) Develops knowledge of language structure (e.g., grammar), language conventions (e.g., spelling and punctuation), media techniques, figurative language and genre to create, critique, and discuss print and nonprint texts.

b. Oral communication.

(1) Understands oral language, listening, and nonverbal communication skills; knows how to analyze communication interactions; and applies related knowledge and skills to teach students to become competent communicators in varied contexts.

(2) Understands the communication process and related theories, knows the purpose and function of communication and understands how to apply this knowledge to teach students to make appropriate and effective choices as senders and receivers of messages in varied contexts.

c. Language development.

(1) Understands inclusive and appropriate language, patterns and dialects across cultures, ethnic groups, geographic regions and social roles.

(2) Develops strategies to improve competency in the English language arts and understanding of content across the curriculum for students whose first language is not English.

d. Young adult literature, American literature, and world literature.

(1) Reads, comprehends, and analyzes a wide range of texts to build an understanding of self as well as the cultures of the United States and the world in order to acquire new information, to respond to the needs and demands of society and the workplace, and for personal fulfillment. Among these texts are fiction and nonfiction, graphic novels, classic and contemporary works, young adult literature, and nonprint texts.

(2) Reads a wide range of literature from many periods in many genres to build an understanding of the many dimensions (e.g., philosophical, ethical, aesthetic) of human experience.

(3) Applies a wide range of strategies to comprehend, interpret, evaluate, and appreciate texts. Draws on prior experience, interactions with other readers and writers, knowledge of word meaning and of other texts, word identification strategies, and an understanding of textual features (e.g., sound-letter correspondence, sentence structure, context, graphics).

(4) Participates as a knowledgeable, reflective, creative, and critical member of a variety of literacy communities.

e. Creative voice.

(1) Understands the art of oral interpretation and how to provide opportunities for students to develop and apply oral interpretation skills in individual and group performances for a variety of audiences, purposes and occasions.

(2) Understands the basic skills of theatre production including acting, stage movement, and basic stage design.

f. Argumentation/debate.

(1) Understands concepts and principles of classical and contemporary rhetoric and is able to plan, prepare, organize, deliver and evaluate speeches and presentations.

(2) Understands argumentation and debate and how to provide students with opportunities to apply skills and strategies for argumentation and debate in a variety of formats and contexts.

g. Journalism.

(1) Understands ethical standards and major legal issues including First Amendment rights and responsibilities relevant to varied communication content. Utilizes strategies to teach students about the importance of freedom of speech in a democratic society and the rights and responsibilities of communicators.

(2) Understands the writing process as it relates to journalism (e.g., brainstorming, questioning, reporting, gathering and synthesizing information, writing, editing, and evaluating the final media product).

(3) Understands a variety of forms of journalistic writing (e.g., news, sports, features, opinion, Web-based) and the appropriate styles (e.g., Associated Press, multiple sources with attribution, punctuation) and additional forms unique to journalism (e.g., headlines, cutlines, and/or visual presentations).

h. Mass media production.

(1) Understands the role of the media in a democracy and the importance of preserving that role.
 (2) Understands how to interpret and analyze various types of mass media messages in order for students to become critical consumers.

(3) Develops the technological skills needed to package media products effectively using various forms of journalistic design with a range of visual and auditory methods.

i. Reading strategies (if not completed as part of the professional education core requirements).

(1) Uses a variety of skills and strategies to comprehend and interpret complex fiction, nonfiction and informational text.

(2) Reads for a variety of purposes and across content areas.

13.28(7) Foreign language. K-8 and 5-12. Completion of 24 semester hours in each foreign language for which endorsement is sought.

13.28(8) Health. K-8 and 5-12. Completion of 24 semester hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

For holders of physical education or family and consumer science endorsements, completion of 18 credit hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

13.28(9) Family and consumer sciences—general. 5-12. Completion of 24 semester hours in family and consumer sciences to include coursework in lifespan development, parenting and child development education, family studies, consumer resource management, textiles or apparel design and merchandising, housing, foods and nutrition, and foundations of career and technical education as related to family and consumer sciences.

13.28(10) Industrial technology. 5-12. Completion of 24 semester hours in industrial technology to include coursework in manufacturing, construction, energy and power, graphic communications and transportation. The coursework is to include at least 6 semester hours in three different areas.

13.28(11) Journalism. 5-12. Completion of 15 semester hours in journalism to include coursework in writing, editing, production and visual communications.

13.28(12) Mathematics.

a. K-8. Completion of 24 semester hours in mathematics to include coursework in algebra, geometry, number theory, measurement, computer programming, and probability and statistics.

b. 5-12.

(1) Completion of 24 semester hours in mathematics to include a linear algebra or an abstract (modern) algebra course, a geometry course, a two-course sequence in calculus, a computer programming course, a probability and statistics course, and coursework in discrete mathematics.

(2) For holders of the physics 5-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

(3) For holders of the all science 9-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

c. 5-8 algebra for high school credit. For a 5-8 algebra for high school credit endorsement, hold either the K-8 mathematics or middle school mathematics endorsement and complete a college algebra or linear algebra class. This endorsement allows the holder to teach algebra to grades 5-8 for high school credit.

13.28(13) Music.

a. K-8. Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history, and applied music, and a methods course in each of the following: general, choral, and instrumental music.

b. 5-12. Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history (at least two courses), applied music, and conducting, and a methods course in each of the following: general, choral, and instrumental music.

13.28(14) Physical education.

a. K-8. Completion of 24 semester hours in physical education to include coursework in human anatomy, human physiology, movement education, adaptive physical education, personal wellness, human growth and development of children related to physical education, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

b. 5-12. Completion of 24 semester hours in physical education to include coursework in human anatomy, kinesiology, human physiology, human growth and development related to maturational and motor learning, adaptive physical education, curriculum and administration of physical education, personal wellness, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

13.28(15) Reading.

a. K-8 requirements. Completion of 24 semester hours in reading to include all of the following requirements:

(1) Foundations of reading. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of the psychological, sociocultural, and linguistic foundations of reading and writing processes and instruction.

2. The practitioner demonstrates knowledge of a range of research pertaining to reading, writing, and learning, including scientifically based reading research, and knowledge of histories of reading. The range of research encompasses research traditions from the fields of the social sciences and other paradigms appropriate for informing practice.

3. The practitioner demonstrates knowledge of the major components of reading, such as phonemic awareness, word identification, phonics, vocabulary, fluency, and comprehension, and effectively integrates curricular standards with student interests, motivation, and background knowledge.

(2) Reading in the content areas. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

2. The practitioner provides content area instruction in reading and writing that effectively uses a variety of research-based strategies and practices.

(3) Practicum. This requirement includes the following competencies:

1. The practitioner works with licensed professionals who observe, evaluate, and provide feedback on the practitioner's knowledge, dispositions, and performance of the teaching of reading and writing.

2. The practitioner effectively uses reading and writing strategies, materials, and assessments based upon appropriate reading and writing research and works with colleagues and families in the support of children's reading and writing development.

(4) Language development. This requirement includes the following competency: The practitioner uses knowledge of language development and acquisition of reading skills (birth through sixth grade), and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

(5) Oral communication. This requirement includes the following competencies:

1. The practitioner has knowledge of the unique needs and backgrounds of students with language differences and delays.

2. The practitioner uses effective strategies for facilitating the learning of Standard English by all learners.

(6) Written communication. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections; the writing process; the stages of spelling

development; the different types of writing, such as narrative, expressive, persuasive, informational and descriptive; and the connections between oral and written language development to effectively teach writing as communication.

(7) Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

1. The practitioner uses knowledge of a variety of instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification of students' reading proficiencies and needs, for planning and revising instruction for all students, and for communicating the results of ongoing assessments to all stakeholders.

2. The practitioner demonstrates awareness of policies and procedures related to special programs, including Title I.

(8) Children's nonfiction and fiction. This requirement includes the following competency: The practitioner uses knowledge of children's literature for:

1. Modeling the reading and writing of varied genres, including fiction and nonfiction; technology- and media-based information; and nonprint materials;

2. Motivating through the use of texts at multiple levels, representing broad interests, and reflecting varied cultures, linguistic backgrounds, and perspectives; and

3. Matching text complexities to the proficiencies and needs of readers.

(9) Reading instructional strategies. This requirement includes the following competency: The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering effective instruction across the curriculum, for grouping students, and for selecting materials appropriate for learners at various stages of reading and writing development and from varied cultural and linguistic backgrounds.

b. 5-12 requirements. Completion of 24 semester hours in reading to include all of the following requirements:

- (1) Foundations of reading. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of the psychological, sociocultural, and linguistic foundations of reading and writing processes and instruction.

2. The practitioner demonstrates knowledge of a range of research pertaining to reading, writing, and learning, including scientifically based reading research, and knowledge of histories of reading. The range of research encompasses research traditions from the fields of the social sciences and other paradigms appropriate for informing practice.

3. The practitioner demonstrates knowledge of the major components of reading such as phonemic awareness, word identification, phonics, vocabulary, fluency, and comprehension, and integrates curricular standards with student interests, motivation, and background knowledge.

- (2) Reading in the content areas. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

2. The practitioner provides content area instruction in reading and writing that effectively uses a variety of research-based strategies and practices.

- (3) Practicum. This requirement includes the following competencies:

1. The practitioner works with licensed professionals who observe, evaluate, and provide feedback on the practitioner's knowledge, dispositions, and performance of the teaching of reading and writing.

2. The practitioner effectively uses reading and writing strategies, materials, and assessments based upon appropriate reading and writing research, and works with colleagues and families in the support of students' reading and writing development.

- (4) Language development. This requirement includes the following competency: The practitioner uses knowledge of the relationship of language acquisition and language development with the acquisition and development of reading skills, and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

(5) Oral communication. This requirement includes the following competency: The practitioner demonstrates knowledge of the unique needs and backgrounds of students with language differences and uses effective strategies for facilitating the learning of Standard English by all learners.

(6) Written communication. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections to teach the skills and processes necessary for writing narrative, expressive, persuasive, informational, and descriptive texts, including text structures and mechanics such as grammar, usage, and spelling.

(7) Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

1. The practitioner uses knowledge of a variety of instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification of students' reading proficiencies and needs, for planning and revising instruction for all students, and for communicating the results of ongoing assessments to all stakeholders.

2. The practitioner demonstrates awareness of policies and procedures related to special programs.

(8) Adolescent or young adult nonfiction and fiction. This requirement includes the following competency: The practitioner uses knowledge of adolescent or young adult literature for:

1. Modeling the reading and writing of varied genres, including fiction and nonfiction; technology and media-based information; and nonprint materials;

2. Motivating through the use of texts at multiple levels, representing broad interests, and reflecting varied cultures, linguistic backgrounds and perspectives; and

3. Matching text complexities to the proficiencies and needs of readers.

(9) Reading instructional strategies. This requirement includes the following competency: The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering instruction across the curriculum, for grouping students, and for selecting materials appropriate for learners at various stages of reading and writing development and from varied cultural and linguistic backgrounds.

13.28(16) Reading specialist. K-12. The applicant must have met the requirements for the standard license and a teaching endorsement, and present evidence of at least one year of experience which included the teaching of reading as a significant part of the responsibility.

a. Authorization. The holder of this endorsement is authorized to serve as a reading specialist in kindergarten and grades one through twelve.

b. Program requirements. Degree—master's.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. This sequence is to be at least 27 semester hours to include the following:

- (1) Educational psychology/human growth and development.

- (2) Educational measurement and evaluation.

- (3) Foundations of reading.

- (4) Diagnosis of reading problems.

- (5) Remedial reading.

- (6) Psychology of reading.

- (7) Language learning and reading disabilities.

- (8) Practicum in reading.

- (9) Administration and supervision of reading programs at the elementary and secondary levels.

13.28(17) Science.

a. Science—basic. K-8.

- (1) Required coursework. Completion of at least 24 semester hours in science to include 12 hours in physical sciences, 6 hours in biology, and 6 hours in earth/space sciences.

- (2) Pedagogy competencies.

1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.

2. Understand the fundamental facts and concepts in major science disciplines.

3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.
4. Be able to use scientific understanding when dealing with personal and societal issues.
 - b. *Biological science.* 5-12. Completion of 24 semester hours in biological science or 30 semester hours in the broad area of science to include 15 semester hours in biological science.
 - c. *Chemistry.* 5-12. Completion of 24 semester hours in chemistry or 30 semester hours in the broad area of science to include 15 semester hours in chemistry.
 - d. *Earth science.* 5-12. Completion of 24 semester hours in earth science or 30 semester hours in the broad area of science to include 15 semester hours in earth science.
 - e. *Basic science.* 5-12. Completion of 24 semester hours of credit in science to include the following:
 - (1) Six semester hours of credit in earth and space science to include the following essential concepts and skills:
 1. Understand and apply knowledge of energy in the earth system.
 2. Understand and apply knowledge of geochemical cycles.
 - (2) Six semester hours of credit in life science/biological science to include the following essential concepts and skills:
 1. Understand and apply knowledge of the cell.
 2. Understand and apply knowledge of the molecular basis of heredity.
 3. Understand and apply knowledge of the interdependence of organisms.
 4. Understand and apply knowledge of matter, energy, and organization in living systems.
 5. Understand and apply knowledge of the behavior of organisms.
 - (3) Six semester hours of credit in physics/physical science to include the following essential concepts and skills:
 1. Understand and apply knowledge of the structure of atoms.
 2. Understand and apply knowledge of the structure and properties of matter.
 3. Understand and apply knowledge of motions and forces.
 4. Understand and apply knowledge of interactions of energy and matter.
 - (4) Six semester hours of credit in chemistry to include the following essential concepts and skills:
 1. Understand and apply knowledge of chemical reactions.
 2. Be able to design and conduct scientific investigations.
 - f. *Physical science.* Rescinded IAB 11/14/12, effective 12/19/12.
 - g. *Physics.*
 - (1) 5-12. Completion of 24 semester hours in physics or 30 semester hours in the broad area of science to include 15 semester hours in physics.
 - (2) For holders of the mathematics 5-12 endorsement, completion of:
 1. 12 credits of physics to include coursework in mechanics, electricity, and magnetism; and
 2. A methods class that includes inquiry-based instruction, resource management, and laboratory safety.
 - (3) For holders of the chemistry 5-12 endorsement, completion of 12 credits of physics to include coursework in mechanics, electricity, and magnetism.
 - h. *All science I.* Rescinded IAB 11/14/12, effective 12/19/12.
 - i. *All science.* 5-12.
 - (1) Completion of 36 semester hours of credit in science to include the following:
 1. Nine semester hours of credit in earth and space science to include the following essential concepts and skills:
 - Understand and apply knowledge of energy in the earth system.
 - Understand and apply knowledge of geochemical cycles.
 - Understand and apply knowledge of the origin and evolution of the earth system.
 - Understand and apply knowledge of the origin and evolution of the universe.
 2. Nine semester hours of credit in life science/biological science to include the following essential concepts and skills:

- Understand and apply knowledge of the cell.
 - Understand and apply knowledge of the molecular basis of heredity.
 - Understand and apply knowledge of the interdependence of organisms.
 - Understand and apply knowledge of matter, energy, and organization in living systems.
 - Understand and apply knowledge of the behavior of organisms.
 - Understand and apply knowledge of biological evolution.
3. Nine semester hours of credit in physics/physical science to include the following essential concepts and skills:
- Understand and apply knowledge of the structure of atoms.
 - Understand and apply knowledge of the structure and properties of matter.
 - Understand and apply knowledge of motions and forces.
 - Understand and apply knowledge of interactions of energy and matter.
 - Understand and apply knowledge of conservation of energy and increase in disorder.
4. Nine semester hours of credit in chemistry to include the following essential concepts and skills:
- Understand and apply knowledge of chemical reactions.
 - Be able to design and conduct scientific investigations.
- (2) Pedagogy competencies.
1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.
 2. Understand the fundamental facts and concepts in major science disciplines.
 3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.
 4. Be able to use scientific understanding when dealing with personal and societal issues.
- 13.28(18) Social sciences.**
- a. *American government.* 5-12. Completion of 24 semester hours in American government or 30 semester hours in the broad area of social sciences to include 15 semester hours in American government.
 - b. *American history.* 5-12. Completion of 24 semester hours in American history or 30 semester hours in the broad area of social sciences to include 15 semester hours in American history.
 - c. *Anthropology.* 5-12. Completion of 24 semester hours in anthropology or 30 semester hours in the broad area of social sciences to include 15 semester hours in anthropology.
 - d. *Economics.* 5-12. Completion of 24 semester hours in economics or 30 semester hours in the broad area of social sciences to include 15 semester hours in economics, or 30 semester hours in the broad area of business to include 15 semester hours in economics.
 - e. *Geography.* 5-12. Completion of 24 semester hours in geography or 30 semester hours in the broad area of social sciences to include 15 semester hours in geography.
 - f. *History.* K-8. Completion of 24 semester hours in history to include at least 9 semester hours in American history and 9 semester hours in world history.
 - g. *Psychology.* 5-12. Completion of 24 semester hours in psychology or 30 semester hours in the broad area of social sciences to include 15 semester hours in psychology.
 - h. *Social studies.* K-8. Completion of 24 semester hours in social studies, to include coursework from at least three of these areas: history, sociology, economics, American government, psychology and geography.
 - i. *Sociology.* 5-12. Completion of 24 semester hours in sociology or 30 semester hours in the broad area of social sciences to include 15 semester hours in sociology.
 - j. *World history.* 5-12. Completion of 24 semester hours in world history or 30 semester hours in the broad area of social sciences to include 15 semester hours in world history.
 - k. *All social sciences.* 5-12. Completion of 51 semester hours in the social sciences to include 9 semester hours in each of American and world history, 9 semester hours in government, 6 semester hours in sociology, 6 semester hours in psychology other than educational psychology, 6 semester hours in geography, and 6 semester hours in economics.

13.28(19) *Speech communication/theatre.*

a. K-8. Completion of 20 semester hours in speech communication/theatre to include coursework in speech communication, creative drama or theatre, and oral interpretation.

b. 5-12. Completion of 24 semester hours in speech communication/theatre to include coursework in speech communication, oral interpretation, creative drama or theatre, argumentation and debate, and mass media communication.

13.28(20) *English as a second language (ESL). K-12.*

a. *Authorization.* The holder of this endorsement is authorized to teach English as a second language in kindergarten and grades one through twelve.

b. *Content.* Completion of 18 semester hours of coursework in English as a second language to include the following:

(1) Knowledge of pedagogy to include the following:

1. Methods and curriculum to include the following:

- Bilingual and ESL methods.
 - Literacy in native and second language.
 - Methods for subject matter content.
 - Adaptation and modification of curriculum.
2. Assessment to include language proficiency and academic content.

(2) Knowledge of linguistics to include the following:

1. Psycholinguistics and sociolinguistics.
2. Language acquisition and proficiency to include the following:
- Knowledge of first and second language proficiency.
 - Knowledge of first and second language acquisition.
 - Language to include structure and grammar of English.

(3) Knowledge of cultural and linguistic diversity to include the following:

1. History.
2. Theory, models, and research.
3. Policy and legislation.

(4) Current issues with transient populations.

13.28(21) *Elementary school teacher librarian.*

a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade eight.

b. *Content.* Completion of 24 semester hours in school library coursework to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in children.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among children, based on familiarity with selection tools and current trends in literature for children.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the elementary level.

13.28(22) Secondary school teacher librarian.

a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher librarian in grades five through twelve.

b. *Content.* Completion of 24 semester hours in school library coursework to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in young adults.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among young adults, based on familiarity with selection tools and current trends in literature for young adults.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the secondary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the secondary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the secondary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the secondary level.

13.28(23) School teacher librarian. PK-12.

a. Authorization. The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade twelve. The applicant must be the holder of or eligible for the initial license.

b. Program requirements. Degree—master's.

c. Content. Completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements. This sequence is to be at least 30 semester hours in school library coursework, to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy for youth of all ages.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading, based on familiarity with selection tools and current trends in literature for youth of all ages.

3. Practitioners understand how to develop a collection of reading and informational materials in print and digital formats that supports the diverse developmental, cultural, social and linguistic needs of all learners and their communities.

4. Practitioners model and teach reading comprehension strategies to create meaning from text for youth of all ages.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

8. Practitioners understand the process of collecting, interpreting, and using data to develop new knowledge to improve the school library program.

9. Practitioners employ the methods of research in library and information science.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users of all ages.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

5. Practitioners demonstrate knowledge of best practices related to planning, budgeting (including alternative funding), organizing, and evaluating human and information resources and facilities to ensure equitable access.

6. Practitioners understand strategic planning to ensure that the school library program addresses the needs of diverse communities.

7. Practitioners advocate for school library and information programs, resources, and services among stakeholders.

8. Practitioners promote initiatives and partnerships to further the mission and goals of the school library program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary and secondary levels.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary and secondary levels.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary and secondary levels.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula.

13.28(24) Talented and gifted teacher.

a. *Authorization.* The holder of this endorsement is authorized to serve as a teacher or a coordinator of programs for the talented and gifted from the prekindergarten level through grade twelve. This authorization does not permit general classroom teaching at any level except that level or area for which the holder is eligible or holds the specific endorsement.

b. *Program requirements—content.* Completion of 12 undergraduate or graduate semester hours of coursework in the area of the talented and gifted to include the following:

(1) Psychology of the gifted.

1. Social needs.

2. Emotional needs.

(2) Programming for the gifted.

1. Prekindergarten-12 identification.

2. Differentiation strategies.

3. Collaborative teaching skills.

4. Program goals and performance measures.

5. Program evaluation.

(3) Practicum experience in gifted programs.

NOTE: Teachers in specific subject areas will not be required to hold this endorsement if they teach gifted students in their respective endorsement areas.

13.28(25) American Sign Language endorsement.

a. Authorization. The holder of this endorsement is authorized to teach American Sign Language in kindergarten and grades one through twelve.

b. Content. Completion of 18 semester hours of coursework in American Sign Language to include the following:

- (1) Second language acquisition.
 - (2) Sociology of the deaf community.
 - (3) Linguistic structure of American Sign Language.
 - (4) Language teaching methodology specific to American Sign Language.
 - (5) Teaching the culture of deaf people.
 - (6) Assessment of students in an American Sign Language program.
- c. Other.* Be the holder of or be eligible for one other teaching endorsement.

13.28(26) Elementary professional school counselor.

a. Authorization. The holder of this endorsement is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

b. Program requirements. Master's degree from an accredited institution of higher education.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include the following:

- (1) Nature and needs of individuals at all developmental levels.
 1. Develop strategies for facilitating development through the transition from childhood to adolescence and from adolescence to young adulthood.
 2. Apply knowledge of learning and personality development to assist students in developing their full potential.
- (2) Social and cultural foundations.
 1. Demonstrate awareness of and sensitivity to the unique social, cultural, and economic circumstances of students and their racial/ethnic, gender, age, physical, and learning differences.
 2. Demonstrate sensitivity to the nature and the functioning of the student within the family, school and community contexts.
 3. Demonstrate the counseling and consultation skills needed to facilitate informed and appropriate action in response to the needs of students.
- (3) Fostering of relationships.
 1. Employ effective counseling and consultation skills with students, parents, colleagues, administrators, and others.
 2. Communicate effectively with parents, colleagues, students and administrators.
 3. Counsel students in the areas of personal, social, academic, and career development.
 4. Assist families in helping their children address the personal, social, and emotional concerns and problems that may impede educational progress.
 5. Implement developmentally appropriate counseling interventions with children and adolescents.
 6. Demonstrate the ability to negotiate and move individuals and groups toward consensus or conflict resolution or both.
 7. Refer students for specialized help when appropriate.
 8. Value the well-being of the students as paramount in the counseling relationship.
- (4) Group work.
 1. Implement developmentally appropriate interventions involving group dynamics, counseling theories, group counseling methods and skills, and other group work approaches.
 2. Apply knowledge of group counseling in implementing appropriate group processes for elementary, middle school, and secondary students.
- (5) Career development, education, and postsecondary planning.

1. Assist students in the assessment of their individual strengths, weaknesses, and differences, including those that relate to academic achievement and future plans.
 2. Apply knowledge of career assessment and career choice programs.
 3. Implement occupational and educational placement, follow-up and evaluation.
 4. Develop a counseling network and provide resources for use by students in personalizing the exploration of postsecondary educational opportunities.
- (6) Assessment and evaluation.
1. Demonstrate individual and group approaches to assessment and evaluation.
 2. Demonstrate an understanding of the proper administration and uses of standardized tests.
 3. Apply knowledge of test administration, scoring, and measurement concerns.
 4. Apply evaluation procedures for monitoring student achievement.
 5. Apply assessment information in program design and program modifications to address students' needs.
 6. Apply knowledge of legal and ethical issues related to assessment and student records.
- (7) Professional orientation.
1. Apply knowledge of history, roles, organizational structures, ethics, standards, and credentialing.
 2. Maintain a high level of professional knowledge and skills.
 3. Apply knowledge of professional and ethical standards to the practice of school counseling.
 4. Articulate the professional school counselor role to school personnel, parents, community, and students.
- (8) School counseling skills.
1. Design, implement, and evaluate a comprehensive, developmental school counseling program.
 2. Implement and evaluate specific strategies designed to meet program goals and objectives.
 3. Consult and coordinate efforts with resource persons, specialists, businesses, and agencies outside the school to promote program objectives.
 4. Provide information appropriate to the particular educational transition and assist students in understanding the relationship that their curricular experiences and academic achievements will have on subsequent educational opportunities.
 5. Assist parents and families in order to provide a supportive environment in which students can become effective learners and achieve success in pursuit of appropriate educational goals.
 6. Provide training, orientation, and consultation assistance to faculty, administrators, staff, and school officials to assist them in responding to the social, emotional, and educational development of all students.
 7. Collaborate with teachers, administrators, and other educators in ensuring that appropriate educational experiences are provided that allow all students to achieve success.
 8. Assist in the process of identifying and addressing the needs of the exceptional student.
 9. Apply knowledge of legal and ethical issues related to child abuse and mandatory reporting.
 10. Advocate for the educational needs of students and work to ensure that these needs are addressed at every level of the school experience.
 11. Promote use of school counseling and educational and career planning activities and programs involving the total school community to provide a positive school climate.
- (9) Classroom management.
1. Apply effective classroom management strategies as demonstrated in delivery of classroom and large group school counseling curriculum.
 2. Consult with teachers and parents about effective classroom management and behavior management strategies.
- (10) Curriculum.
1. Write classroom lessons including objectives, learning activities, and discussion questions.
 2. Utilize various methods of evaluating what students have learned in classroom lessons.

3. Demonstrate competency in conducting classroom and other large group activities, utilizing an effective lesson plan design, engaging students in the learning process, and employing age-appropriate classroom management strategies.

4. Design a classroom unit of developmentally appropriate learning experiences.

5. Demonstrate knowledge in writing standards and benchmarks for curriculum.

(11) Learning theory.

1. Identify and consult with teachers about how to create a positive learning environment utilizing such factors as effective classroom management strategies, building a sense of community in the classroom, and cooperative learning experiences.

2. Identify and consult with teachers regarding teaching strategies designed to motivate students using small group learning activities, experiential learning activities, student mentoring programs, and shared decision-making opportunities.

3. Demonstrate knowledge of child and adolescent development and identify developmentally appropriate teaching and learning strategies.

(12) Teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with elementary and middle school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group counseling, developmental classroom guidance, and consultation.

13.28(27) Secondary professional school counselor.

a. Authorization. The holder of this endorsement is authorized to serve as a professional school counselor in grades five through twelve.

b. Program requirements. Master's degree from an accredited institution of higher education.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in subparagraphs 13.28(26) "c"(1) to (11).

(2) The teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with middle and secondary school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group work, developmental classroom guidance, and consultation.

13.28(28) School nurse endorsement. The school nurse endorsement does not authorize general classroom teaching, although it does authorize the holder to teach health at all grade levels. Alternatively, a nurse may obtain a statement of professional recognition (SPR) from the board of educational examiners, in accordance with the provisions set out in 282—Chapter 16, Statements of Professional Recognition (SPR).

a. Authorization. The holder of this endorsement is authorized to provide service as a school nurse at the prekindergarten and kindergarten levels and in grades one through twelve.

b. Content.

(1) Organization and administration of school nurse services including the appraisal of the health needs of children and youth.

(2) School-community relationships and resources/coordination of school and community resources to serve the health needs of children and youth.

(3) Knowledge and understanding of the health needs of exceptional children.

(4) Health education.

c. Other. Hold a license as a registered nurse issued by the Iowa board of nursing.

13.28(29) Athletic coach. K-12. An applicant for the coaching endorsement must hold a teacher's license with one of the teaching endorsements.

a. Authorization. The holder of this endorsement may serve as a head coach or an assistant coach in kindergarten and grades one through twelve.

b. Program requirements.

- (1) One semester hour college or university course in the structure and function of the human body in relation to physical activity, and
- (2) One semester hour college or university course in human growth and development of children and youth as related to physical activity, and
- (3) Two semester hour college or university course in athletic conditioning, care and prevention of injuries and first aid as related to physical activity, and
- (4) One semester hour college or university course in the theory of coaching interscholastic athletics, and
- (5) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

13.28(30) Content specialist endorsement. The applicant must have met the requirements for the standard license and a teaching endorsement.

a. Authorization. The holder of this endorsement is authorized to serve as a content specialist in kindergarten and grades one through twelve in the specific content listed on the authorization.

b. Requirements.

- (1) Hold a master's degree in the content area or complete 30 semester hours of college course work in the content area.
- (2) Complete 15 semester hours of credit in professional development in three or more of the following areas:
 1. Using research-based content teaching strategies;
 2. Integrating appropriate technology into the learning experiences for the specific content;
 3. Engaging the learner in the content through knowledge of learner needs and interests;
 4. Using reflective thinking to solve problems in the content area;
 5. Making data-driven decisions in the content area;
 6. Utilizing project-based learning in the content area;
 7. Developing critical thinking skills in the content area;
 8. Forming partnerships to collaborate with content experts within the community;
 9. Relating content with other content areas;
 10. Facilitating content learning in large and small teams;
 11. Implementing response to intervention (RTI) to close achievement gaps in the content area.
- (3) Complete an internship, externship, or professional experience for a minimum of 90 contact hours in the content area.

13.28(31) Engineering. 5-12.

a. Completion of 24 semester hours in engineering coursework.

b. Methods and strategies of STEM instruction or methods of teaching science or mathematics.

13.28(32) STEM.

a. K-8.

- (1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in kindergarten through grade eight.
- (2) Program requirements. Be the holder of the teacher—elementary classroom endorsement.
- (3) Content.
 1. Completion of a minimum of 12 semester hours of college-level science.
 2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.
 3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:
 - Engineering and technological design courses for education majors;
 - Technology or engineering content coursework.
 4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
 - Promoting learning through purposeful, authentic, real-world connections;
 - Integration of content and context of each of the STEM disciplines;
 - Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
 - Curriculum and standards mapping;
 - Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
 - Assessment of integrative learning approaches;
 - Information literacy skills in STEM;
 - Processes of science and scientific inquiry;
 - Mathematical problem-solving models;
 - Communicating to a variety of audiences;
 - Classroom management in project-based classrooms;
 - Instructional strategies for the inclusive classroom;
 - Computational thinking;
 - Mathematical and technological modeling.
5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:
- Completing a STEM research experience;
 - Participating in a STEM internship at a STEM business or informal education organization; or
 - Leading a STEM extracurricular activity.
- b. 5-8.
- (1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in grades five through eight.
- (2) Program requirements. Be the holder of a 5-12 science, mathematics, or industrial technology endorsement or 5-8 middle school mathematics or science endorsement.
- (3) Content.
1. Completion of a minimum of 12 semester hours of college-level science.
 2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.
 3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:
 - Engineering and technological design courses for education majors;
 - Technology or engineering content coursework.
 4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:
 - Comparing and contrasting the nature and goals of each of the STEM disciplines;
 - Promoting learning through purposeful, authentic, real-world connections;
 - Integration of content and context of each of the STEM disciplines;
 - Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
 - Curriculum and standards mapping;
 - Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
 - Assessment of integrative learning approaches;
 - Information literacy skills in STEM;
 - Processes of science and scientific inquiry;
 - Mathematical problem-solving models;

- Communicating to a variety of audiences;
 - Classroom management in project-based classrooms;
 - Instructional strategies for the inclusive classroom;
 - Computational thinking;
 - Mathematical and technological modeling.
5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:
- Completing a STEM research experience;
 - Participating in a STEM internship at a STEM business or informal education organization; or
 - Leading a STEM extracurricular activity.
- c. *Specialist K-12.*
- (1) Authorization. The holder of this endorsement is authorized to serve as a STEM specialist in kindergarten and grades one through twelve.
- (2) Program requirements.
1. The applicant must have met the requirements for a standard Iowa teaching license and a teaching endorsement in mathematics, science, engineering, industrial technology, or agriculture.
2. The applicant must hold a master's degree from a regionally accredited institution. The master's degree must be in math, science, engineering or technology or another area with at least 12 hours of college-level science and at least 12 hours of college-level math (or completion of Calculus I) to include coursework in computer programming.
- (3) Content.
1. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:
- Engineering and technological design courses for education majors;
 - Technology or engineering content coursework.
2. Completion of 9 semester hours in professional development to include the following essential concepts and skills:
- STEM curriculum and methods:
 - Comparing and contrasting the nature and goals of each of the STEM disciplines;
 - Promoting learning through purposeful, authentic, real-world connections;
 - Integration of content and context of each of the STEM disciplines;
 - Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
 - Curriculum/standards mapping;
 - Assessment of integrative learning approaches;
 - Information literacy skills in STEM;
 - Processes of science/scientific inquiry;
 - Mathematical problem-solving models;
 - Classroom management in project-based classrooms;
 - Instructional strategies for the inclusive classroom;
 - Computational thinking;
 - Mathematical and technological modeling.
 - STEM experiential learning:
 - Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
 - STEM research experiences;
 - STEM internship at a STEM business or informal education organization;
 - STEM extracurricular activity;
 - Communicating to a variety of audiences.
 - Leadership in STEM:

- STEM curriculum development and assessment;
- Curriculum mapping;
- Assessment of student engagement;
- STEM across the curriculum;
- Research on best practices in STEM;
- STEM curriculum accessibility for all students.

3. Completion of an internship/externship professional experience or prior professional experience in STEM for a minimum of 90 contact hours.

13.28(33) *Multioccupations.* Completion of any 5-12 endorsement and, in addition thereto, coursework in foundations of career and technical education, coordination of cooperative programs, and competency-based curriculum development. Four thousand hours of career and technical experience in two or more occupations. The multioccupations endorsement also authorizes the holder to supervise students in cooperative programs, school-to-work programs, and similar programs in which the student is placed in school-sponsored, on-the-job situations.

[**ARC 7986B**, IAB 7/29/09, effective 9/2/09; **ARC 8248B**, IAB 11/4/09, effective 10/12/09; **ARC 8403B**, IAB 12/16/09, effective 1/20/10; **ARC 9070B**, IAB 9/8/10, effective 10/13/10; **ARC 9071B**, IAB 9/8/10, effective 10/13/10; **ARC 9210B**, IAB 11/3/10, effective 12/8/10; **ARC 9211B**, IAB 11/3/10, effective 12/8/10; **ARC 9212B**, IAB 11/3/10, effective 12/8/10; **ARC 9838B**, IAB 11/2/11, effective 12/7/11; **ARC 9839B**, IAB 11/2/11, effective 12/7/11; **ARC 0448C**, IAB 11/14/12, effective 12/19/12; **ARC 0449C**, IAB 11/14/12, effective 12/19/12; **ARC 0866C**, IAB 7/24/13, effective 8/28/13; **ARC 0875C**, IAB 7/24/13, effective 8/28/13; **ARC 0986C**, IAB 9/4/13, effective 10/9/13; **ARC 1085C**, IAB 10/16/13, effective 11/20/13; **ARC 1171C**, IAB 11/13/13, effective 12/18/13; **ARC 1328C**, IAB 2/19/14, effective 3/26/14; **ARC 1327C**, IAB 2/19/14, effective 3/26/14; **ARC 2015C**, IAB 6/10/15, effective 7/15/15; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.29(272) Adding, removing or reinstating a teaching endorsement.

13.29(1) *Adding an endorsement.* After the issuance of a teaching license, an individual may add other endorsements to that license upon proper application, provided current requirements for that endorsement have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

a. Options. To add an endorsement, the applicant must follow one of these options:

(1) Option 1. Receive the Iowa teacher education institution's recommendation that the current approved program requirements for the endorsement have been met.

(2) Option 2. Receive verification from the Iowa teacher education institution that the minimum state requirements for the endorsement have been met in lieu of the institution's approved program.

(3) Option 3. Apply for a review of the transcripts by the board of educational examiners' staff to determine if all Iowa requirements have been met. The applicant must submit documentation that all of the Iowa requirements have been met by filing transcripts and supporting documentation for review. The fee for the transcript evaluation is in 282—Chapter 12. This fee shall be in addition to the fee for adding the endorsement.

b. Additional requirements for adding an endorsement.

(1) In addition to meeting the requirements for Iowa licensure, applicants for endorsements shall have completed a methods class appropriate for teaching the general subject area of the endorsement added.

(2) Practitioners who are adding an elementary or early childhood endorsement and have not student taught on the elementary or early childhood level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

(3) Practitioners who are adding a secondary teaching endorsement and have not student taught on the secondary level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

(4) Practitioners holding the K-8 endorsement in the content area of the 5-12 endorsement being added may satisfy the requirement for the secondary methods class and the teaching practicum by completing all required coursework and presenting verification of competence. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the performance of the applicant at the secondary level. This verification of competence may be submitted

at any time during the term of the Class B license. The practitioner must obtain a Class B license while practicing with the 5-12 endorsement.

13.29(2) Removal of an endorsement; reinstatement of removed endorsement.

a. Removal of an endorsement. A practitioner may remove an endorsement from the practitioner's license as follows:

(1) To remove an endorsement, the practitioner shall meet the following conditions:

1. A practitioner who holds a standard or master educator license is eligible to request removal of an endorsement from the license if the practitioner has not taught in the subject or assignment area of the endorsement in the five years prior to the request for removal of the endorsement, and

2. The practitioner must submit a notarized written application form furnished by the board of educational examiners to remove an endorsement at the time of licensure renewal (licensure renewal is limited to one calendar year prior to the expiration date of the current license), and

3. The application must be signed by the superintendent or designee in the district in which the practitioner is under contract. The superintendent's signature shall serve as notification and acknowledgment of the practitioner's intent to remove an endorsement from the practitioner's license. The absence of the superintendent's or designee's signature does not impede the removal process.

(2) The endorsement shall be removed from the license at the time of application.

(3) If a practitioner is not employed and submits an application, the provisions of 13.29(2) "a"(1)"3" shall not be required.

(4) If a practitioner submits an application that does not meet the criteria listed in 13.29(2) "a"(1)"1" to "3," the application will be rendered void and the practitioner will forfeit the processing fee.

(5) The executive director has the authority to approve or deny the request for removal. Any denial is subject to the appeal process set forth in rule 282—11.35(272).

b. Reinstatement of a removed endorsement.

(1) If the practitioner wants to add the removed endorsement at a future date, all coursework for the endorsement must be completed within the five years preceding the application to add the endorsement.

(2) The practitioner must meet the current endorsement requirements when making application.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—13.30(272) Licenses—issue dates, corrections, duplicates, and fraud.

13.30(1) Issue date on original license. A license is valid only from and after the date of issuance.

13.30(2) Correcting licenses. If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

13.30(3) Duplicate licenses. Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

13.30(4) Fraud in procurement or renewal of licenses. Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

These rules are intended to implement Iowa Code chapter 272 and 2014 Iowa Acts, chapter 1116, division VI.

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CHAPTER 14
SPECIAL EDUCATION ENDORSEMENTS
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 15]

282—14.1(272) Special education teaching endorsements.

14.1(1) Program requirements.

- a. The applicant must meet the requirement in rules 282—13.1(272) and 282—13.5(272).
- b. The applicant must complete pre-student teaching field-based experiences in special education.
- c. Student teaching. Each applicant for an Iowa license with a special education instructional endorsement must file evidence of completing an approved student teaching program in special education. This experience must be full-time in an approved special education classroom. An approved special education classroom is one which is recognized by the state in terms of the respective state rules for special education. This special education student teaching experience shall qualify for each special education instructional endorsement sought on an original application for Iowa licensure if at the same grade level.
- d. The applicant must meet the requirements to add an endorsement in rule 282—13.29(272).

14.1(2) Adding special education instructional endorsements to Iowa licenses.

- a. After the issuance of a practitioner license, an individual may add other special education instructional endorsements to that license upon proper application provided current requirements for the specific endorsement(s) have been met.
- b. If an applicant is seeking to add a special education instructional endorsement at the same level, elementary or secondary, as other endorsements held, the student teaching component set out in the rules for added endorsement areas is not required.
- c. If the applicant holds the K-8 special education endorsement for the 5-12 endorsement area being added, the applicant may satisfy the requirements for the secondary methods class and the student teaching experience by completing all the required coursework and presenting verification of competence of teaching a minimum of two years while properly licensed. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the performance of the applicant at the secondary level.
- d. An updated license with expiration date unchanged from the original or renewed license will be prepared. Licensure procedures and requirements are set out in 282—Chapter 13.
[ARC 8248B, IAB 11/4/09, effective 10/12/09]

282—14.2(272) Specific requirements. For each of the following teaching endorsements in special education, the applicant must have completed 24 semester hours in special education.

14.2(1) Early childhood—special education.

- a. This endorsement authorizes instruction at the PK-K level only for instructional special education programs without regard to the instructional model.
- b. The applicant must present evidence of having completed the following program requirements.
 - (1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.
 - (2) Characteristics of learners. Preparation which includes an overview of current trends in educational programming and theories of child development, both typical and atypical; the identification of pre-, peri-, and postnatal development and factors that affect children's development and learning. Identification of specific disabilities, including the etiology, characteristics, and classification of common disabilities in young children. Application of the knowledge of cultural and linguistic diversity and the significant sociocultural context for the development of and learning in young children.
 - (3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology

used in the assessment of various disabling conditions. Assess children's cognitive, social-emotional, communication, motor, adaptive, and aesthetic development; and select, adapt, and administer assessment instruments and procedures for specific sensory and motor disabilities.

(4) **Methods and strategies.** Methods and strategies which include numerous models to plan and implement appropriate curricular and instructional practices based on knowledge of individual children, the family, the community, and curricular goals and content. Select intervention curricula and methods for children with specific disabilities including motor, sensory, health, communication, social-emotional and cognitive disabilities. Implement developmentally and functionally appropriate individual and group activities using a variety of formats; develop and implement an integrated curriculum that focuses on special education children from birth to age six, and incorporate information and strategies from multiple disciplines in the design of intervention strategies. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(5) **Managing student behavior and social interaction skills.** Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) **Communication and collaborative partnerships.** Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) **Student teaching.** Student teaching in a PK-K special education program.

14.2(2) Instructional strategist I: mild and moderate.

a. Option 1—K-8 mild and moderate. This endorsement authorizes instruction in all K-8 mild and moderate instructional special education programs without regard to the instructional model. An applicant for this option must complete the following requirement and must hold a regular education endorsement. See rule 282—13.26(272). The applicant must present evidence of having completed the following program requirements.

(1) **Foundations of special education.** The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

(2) **Characteristics of learners.** Preparation which includes various etiologies of mild and moderate disabilities, an overview of current trends in educational programming for mild and moderate disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming, and includes the general developmental, academic, social, career and functional characteristics of individuals with mild and moderate disabilities as the characteristics relate to levels of instructional support required, and the psychological and social-emotional characteristics of individuals with mild and moderate disabilities.

(3) **Assessment, diagnosis and evaluation.** Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of the mildly and moderately disabled, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at the K-8 level. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Student teaching. Student teaching in a K-8 mild and moderate special education program.

b. Option 2—K-8 mild and moderate. To obtain this endorsement, the applicant must hold a valid Iowa license with either a K-8 or 5-12 special education instructional endorsement and must meet the following basic requirements in addition to those set out in paragraph 14.2(2) "a."

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children, unless completed as part of the professional education core.

(2) Methods and materials for teaching elementary language arts.

(3) Remedial reading.

(4) Elementary curriculum methods and material, unless completed as part of another elementary level endorsement program (e.g., rule 282—13.26(272) or a similar elementary endorsement program).

(5) Methods and materials for teaching elementary mathematics.

c. Option 1—5-12 mild and moderate. This endorsement authorizes instruction in all 5-12 mild and moderate instructional special education programs without regard to the instructional model. An applicant for this option must complete the following requirements and must hold a regular education endorsement. See rule 282—13.28(272). The applicant must present evidence of having completed the following program requirements.

(1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

(2) Characteristics of learners. Preparation which includes various etiologies of mild and moderate disabilities, an overview of current trends in educational programming for mild and moderate disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming, and includes the general developmental, academic, social, career and functional characteristics of individuals with mild and moderate disabilities as the characteristics relate to levels of instructional support required, and the psychological and social-emotional characteristics of individuals with mild and moderate disabilities.

(3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any

specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of the mildly and moderately disabled, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at the 5-12 level. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Transitional collaboration. Sources of services, organizations, and networks for individuals with mild and moderate disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

(8) Student teaching. Student teaching in a 5-12 mild and moderate special education program.

d. Option 2—5-12 mild and moderate. To obtain this endorsement, the applicant must hold a valid Iowa license with either a K-8 or 5-12 special education instructional endorsement and must meet the following basic requirements in addition to those set out in paragraph 14.2(2) "c."

(1) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children, unless completed as part of the professional education core.

(2) Adolescent reading or secondary content area reading.

(3) Secondary or adolescent reading diagnosis and remediation.

(4) Methods and materials for teaching adolescents with mathematics difficulties or mathematics for the secondary level special education teacher.

(5) Secondary methods unless completed as part of the professional education core.

14.2(3) Instructional strategist II: behavior disorders/learning disabilities. This endorsement authorizes instruction in programs serving students with behavior disorders and learning disabilities from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The applicant must present evidence of having completed the following program requirements.

a. Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

b. Characteristics of learners. Preparation which includes various etiologies of behavior disorders and learning disabilities, an overview of current trends in educational programming for students with behavior disorders and learning disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from age 5 to age 21. Preparation in the social, emotional and behavioral characteristics of individuals with behavior disorders and learning disabilities including the impact of such characteristics on classroom learning as well as associated domains such as social functioning and at-risk behaviors

which may lead to involvement with the juvenile justice or mental health system. Preparation in the psychological and social-emotional characteristics of individuals with behavior disorders and learning disabilities must include the major social characteristics of individuals with behavior disorders and the effects of dysfunctional behavior on learning, and the social and emotional aspects of individuals with learning disabilities including social imperceptiveness and juvenile delinquency. Physical development, physical disability and health impairments as they relate to the development and behavior of students with behavior disorders and the medical factors influencing individuals with learning disabilities, including intelligence, perception, memory and language development.

c. Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

d. Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of behavior and learning disabled students, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at all levels from age 5 to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

e. Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

f. Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

g. Transitional collaboration. Sources of services, organizations, and networks for individuals with behavior and learning disabilities, including career, vocational and transitional support to postsecondary settings with maximum opportunities for decision making and full participation in the community.

h. Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

14.2(4) Instructional strategist II: intellectual disabilities. This endorsement authorizes instruction in programs serving students with intellectual disabilities from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The applicant must present evidence of having completed the following program requirements.

a. Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

b. Characteristics of learners. Preparation which includes various etiologies of intellectual disabilities, an overview of current trends in educational programming for students with intellectual disabilities, educational alternatives and related services, and the importance of the multidisciplinary

team in providing more appropriate educational programming from age 5 to age 21. Preparation must also provide for an overview of the general developmental, academic, social, career and functional characteristics of individuals with intellectual disabilities as the characteristics relate to levels of instructional support required. This preparation must include the causes and theories of intellectual disabilities and implications and preventions; the psychological characteristics of students with intellectual and developmental disabilities, including cognition, perception, memory, and language development; medical complications and implications for student support needs, including seizure management, tube feeding, catheterization and CPR; and the medical aspects of intellectual disabilities and their implications for learning. The social-emotional aspects of intellectual disabilities, including adaptive behavior, social competence, social isolation and learned helplessness.

c. Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

d. Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of intellectually disabled students, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques. The focus of these experiences is for students at all levels from age 5 to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction. Proficiency in adapting age-appropriate curriculum to facilitate instruction within the general education setting, to include partial participation of students in tasks, skills facilitation, collaboration, and support from peers with and without disabilities; the ability to select and use augmentative and alternative communications methods and systems. An understanding of the impact of speech-language development on behavior and social interactions. Approaches to create positive learning environments for individuals with special needs and approaches to utilize assistive devices for individuals with special needs. The design and implementation of age-appropriate instruction based on the adaptive skills of students with intellectual disabilities; integrate selected related services into the instructional day of students with intellectual disabilities. Knowledge of culturally responsive functional life skills relevant to independence in the community, personal living, and employment. Use of appropriate physical management techniques including positioning, handling, lifting, relaxation, and range of motion and the use and maintenance of orthotic, prosthetic, and adaptive equipment effectively.

e. Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with intellectual disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

f. Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

g. Transitional collaboration. Sources of services, organizations, and networks for individuals with intellectual disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

h. Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

14.2(5) Instructional strategist II: physical disabilities. This endorsement authorizes instruction in programs serving students with physical disabilities from age 5 to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). The applicant must present evidence of having completed the following program requirements.

a. Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, exceptional child, and including individuals from culturally and linguistically diverse backgrounds.

b. Characteristics of learners. Preparation which includes various etiologies and characteristics of physical disabilities across the life span, secondary health care issues that accompany specific physical disabilities, an overview of current trends in educational programming for students with physical disabilities, educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from age 5 to age 21. Preparation must also provide for an overview of the general developmental, academic, social, career and functional characteristics of individuals with physical disabilities as the characteristics relate to levels of instructional support required.

c. Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

d. Methods and strategies.

(1) Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of physically disabled students, and sources of curriculum materials for individuals with disabilities. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with exceptional learning needs, and related instructional and remedial methods and techniques. The focus of these experiences is for students at all levels from age 5 to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction.

(2) Research-supported instructional practices, strategies, and adaptations necessary to accommodate the physical and communication characteristics of students with physical disabilities, including appropriate assistive technology and alternative positioning to permit students with physical disabilities full participation and access to the general curriculum as well as social environments. Design and implement an instructional program that addresses instruction in independent living skills, vocational skills, and career education for students with physical disabilities and instructional strategies for medical self-management procedures by students.

e. Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with physical disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

f. Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities including transitional support. Knowledge

of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

g. Transitional collaboration. Sources of services, organizations, and networks for individuals with physical disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

h. Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

14.2(6) K-8 mildly disabled endorsement. This endorsement authorizes instruction to mildly disabled children who require special education program adaptations while assigned to a regular classroom for basic instructional purposes, or mildly disabled students placed in a special education class who receive part of their instruction in a regular classroom, or mildly disabled students requiring specially designed instruction while assigned to a regular classroom for basic instructional purposes. To fulfill the requirements for this endorsement, the applicant must:

a. Hold a regular education instruction endorsement at the elementary level. For the elementary level, this is the general elementary classroom endorsement.

b. Hold one of the following endorsements at the elementary level: learning disabilities, mild to moderate intellectual disabilities, behavioral disorders, multicategorical resource room or multicategorical-special class with integration.

14.2(7) 5-12 mildly disabled endorsement. This endorsement authorizes instruction to mildly disabled children who require special education program adaptations while assigned to a regular classroom for basic instructional purposes, or mildly disabled students placed in a special education class who receive part of their instruction in a regular classroom, or mildly disabled students requiring specially designed instruction while assigned to a regular classroom for basic instructional purposes. To fulfill the requirements for this endorsement, the applicant must:

a. Hold a regular education instruction endorsement at the secondary level (grades 5-12).

b. Hold one of the following endorsements at the secondary level: learning disabilities, mild to moderate intellectual disabilities, behavioral disorders, multicategorical resource room or multicategorical-special class with integration.

NOTE: These endorsements are designed for programs serving primarily mildly disabled students; the sensory impaired are not included as “mildly disabled.”

14.2(8) Deaf or hard of hearing endorsement.

a. Option 1. This endorsement authorizes instruction in programs serving students with hearing loss from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). An applicant for this option must complete the following requirements and must have completed an approved program in teaching the deaf or hard of hearing from a recognized Iowa or non-Iowa institution and must hold a regular education endorsement. See 282—Chapter 13.

(1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, and including individuals from culturally and linguistically diverse backgrounds.

(2) Characteristics of learners. Preparation which includes various etiologies of hearing loss, an overview of current trends in educational programming for students with hearing loss and educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from birth to age 21. Preparation in the social, emotional and behavioral characteristics of individuals with hearing loss, including the impact of such characteristics on classroom learning. Knowledge of the anatomy and physiology of the hearing mechanism and knowledge of the development of secondary senses when hearing is impaired, effect of hearing loss on learning experiences, psychological aspects of hearing loss, and effects of medications on the hearing system. Preparation in the psychological and social-emotional characteristics of individuals with

hearing loss to include the major social characteristics of individuals with hearing loss and the effects of this disability on learning, and the social and emotional aspects of individuals with hearing loss. Physical development and potential health impairments as they relate to the development and behavior of students with hearing loss. Components of linguistic and nonlinguistic communication used by individuals who are deaf or hard-of-hearing and communication modes used by and with individuals who are deaf or hard-of-hearing, including current theories of language development in individuals who are deaf or hard-of-hearing.

(3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities, including necessary alternative assessment techniques arising out of the nature of the disability and medical reports and other related diagnostic information. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of students who are deaf or hard-of-hearing and sources of specialized materials for individuals who are deaf or hard-of-hearing. These strategies must include knowledge of teaching academic subjects and language and speech to students who are deaf or hard-of-hearing and have knowledge of American Sign Language. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals who are deaf or hard-of-hearing, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at all levels from birth to age 21. This preparation must include alternatives for teaching skills and strategies to individuals who are deaf or hard-of-hearing who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction. Strategies for teaching technology skills and other instructional aids for students who are deaf or hard-of-hearing.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities, including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Transitional collaboration. Sources of services, organizations, and networks for individuals who are deaf or hard-of-hearing, including career, vocational and transitional support to postsecondary settings with maximum opportunities for decision making and full participation in the community.

(8) Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

b. Option 2. An applicant who holds an endorsement in deaf or hard of hearing issued in another state or who is eligible for such an endorsement but who does not also hold or is not eligible for a regular education endorsement in Iowa (see 282—Chapter 13) must meet the following basic requirements in addition to those set out in paragraph 14.2(8)“a.”

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children unless completed as part of the professional education core.

- (2) Methods and materials of teaching elementary language arts.
- (3) Methods and materials of teaching elementary reading.
- (4) Elementary curriculum methods and materials unless completed as part of another elementary level endorsement program (e.g., rule 282—13.26(272) or a similar elementary endorsement program).
- (5) Methods and materials of teaching elementary mathematics.
- (6) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children unless completed as part of the professional education core.
- (7) Adolescent literacy or secondary content area reading.
- (8) Secondary methods unless completed as part of the professional education core.

14.2(9) *Visually disabled endorsement.*

a. Option 1. This endorsement authorizes instruction in programs serving students with visual disabilities from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8). An applicant for this option must complete the following requirements and must have completed an approved program in visual disabilities from a recognized Iowa or non-Iowa institution and must hold a regular education endorsement. See 282—Chapter 13.

(1) Foundations of special education. The philosophical, historical and legal bases for special education, including the definitions and etiologies of individuals with disabilities, and including individuals from culturally and linguistically diverse backgrounds.

(2) Characteristics of learners. Preparation which includes various etiologies of visual impairment, an overview of current trends in educational programming for students with visual disabilities and educational alternatives and related services, and the importance of the multidisciplinary team in providing more appropriate educational programming from birth to age 21. Preparation in the social, emotional and behavioral characteristics of individuals with visual disabilities, including the impact of such characteristics on classroom learning. Development of the human visual system, development of secondary senses when vision is impaired, effect of visual disability on development, impact of visual disability on learning and experiences, psychological aspects of visual disability, and effects of medications on the visual system. Preparation in the psychological and social-emotional characteristics of individuals with visual disabilities to include the major social characteristics of individuals with visual disabilities and the effects of this disability on learning, and the social and emotional aspects of individuals with visual disabilities. Physical development and potential health impairments as they relate to the development and behavior of students with visual disabilities.

(3) Assessment, diagnosis and evaluation. Legal provisions, regulations and guidelines regarding unbiased assessment and use of psychometric instruments and instructional assessment measures with individuals with disabilities, including necessary alternative assessment techniques arising out of the nature of the disability and medical reports and other related diagnostic information. Application of assessment results to individualized program development and management, and the relationship between assessment and placement decisions. Knowledge of any specialized strategies such as functional behavioral assessment and any specialized terminology used in the assessment of various disabling conditions.

(4) Methods and strategies. Methods and strategies which include numerous models for providing curricular and instructional methodologies utilized in the education of visually disabled students and sources of curriculum materials for individuals with disabilities. These strategies must include knowledge of teaching Braille reading and writing, the skill in teaching handwriting and signature writing to individuals with low vision or who are blind, listening and compensatory auditory skills and typing and keyboarding skills. Curricula for the development of cognitive, academic, social, language and functional life skills for individuals with visual disabilities, and related instructional and remedial methods and techniques, including appropriate assistive technology. The focus of these experiences is for students at all levels from birth to age 21. This preparation must include alternatives for teaching skills and strategies to individuals with visual disabilities who differ in degree and nature of disability, and the integration of appropriate age- and ability-level academic instruction. Strategies for teaching technology skills, other instructional aids for visually disabled students, strategies for teaching organization and study skills, tactual and perceptual skills, adapted physical and recreational skills and

strategies for promoting self-advocacy in individuals with visual disabilities and for structured pre-cane orientation and mobility assessment and instruction.

(5) Managing student behavior and social interaction skills. Preparation in individual behavioral management, behavioral change strategies, and classroom management theories, methods, and techniques for individuals with exceptional learning needs. Theories of behavior problems in individuals with disabilities and the use of nonaversive techniques for the purpose of controlling targeted behavior and maintaining attention of individuals with disabilities. Design, implement, and evaluate instructional programs that enhance an individual's social participation in family, school, and community activities.

(6) Communication and collaborative partnerships. Awareness of the sources of unique services, networks, and organizations for individuals with disabilities, including transitional support. Knowledge of family systems, family dynamics, parent rights, advocacy, multicultural issues, and communication to invite and appreciate many different forms of parent involvement. Strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program. Knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom.

(7) Transitional collaboration. Sources of services, organizations, and networks for individuals with visual disabilities, including career, vocational and transitional support to postschool settings with maximum opportunities for decision making and full participation in the community.

(8) Student teaching. Student teaching in programs across the age levels of this endorsement. If the student teaching program has a unique age-level emphasis (e.g., K-8 or 5-12), there must be planned activities which incorporate interactive experiences at the other age level.

b. Option 2. An applicant who holds an endorsement for visually disabled issued in another state or who is eligible for such an endorsement but who does not also hold or is not eligible for a regular education endorsement in Iowa (see 282—Chapter 13) must meet the following basic requirements in addition to those set out in paragraph 14.2(9)“a.”

(1) Child growth and development with emphasis on the emotional, physical, and mental characteristics of elementary age children unless completed as part of the professional education core.

(2) Methods and materials of teaching elementary language arts.

(3) Methods and materials of teaching elementary reading.

(4) Elementary curriculum methods and materials unless completed as part of another elementary level endorsement program (e.g., rule 282—13.26(272) or a similar elementary endorsement program).

(5) Methods and materials of teaching elementary mathematics.

(6) Adolescent growth and development with emphasis on the emotional, physical, and mental characteristics of adolescent age children unless completed as part of the professional education core.

(7) Adolescent literacy or secondary content area reading.

(8) Secondary methods unless completed as part of the professional education core.

14.2(10) K-12 special education. This endorsement authorizes instruction in all K-12 special education programs without regard to the instructional model for all students identified with disabilities, except students with visual or hearing impairments. The applicant must present evidence of having completed coursework to meet the following program requirements.

a. Foundations of special education. To include cultural and instructional characteristics of students with disabilities, current issues, special education law, individualized education plans, history of special education, inclusive practices, and Iowa service delivery models.

b. Assessment, diagnosis and evaluation. To include diagnostic, formative, and summative assessments (both general and alternate), adaptive behavior skills, data usage in program decision making, and interpretation of standardized assessment.

c. Methods for teaching general education core curriculum. To include one course each in methods for elementary math and literacy.

d. Academic methods and strategies. To include evidence-based models for providing instructional methodologies, adaptation, accommodation and intensive interventions of the K-12 general education curriculum for students with disabilities (including concepts reflected in the Iowa

Core essential elements for individuals with significant intellectual disabilities). The methodology for remediation of literacy and math skills must be included.

e. Preparation in research-based assessment and intervention practices. To include applied behavior analysis (ABA), behavior intervention planning (BIP), cognitive behavioral strategies (e.g., CBM, rational emotive education), de-escalation techniques (e.g., Mandt, CPI), functional behavioral assessment (FBA), and positive behavior interventions and supports (PBIS), in order to increase or promote language and communication development; emotional and social health; positive social interaction, personal satisfaction, and self-determination; decision-making skills; and independent functioning at school and home and in the community.

f. Collaborative and transition partnerships. To include awareness of the services, networks, and organizations available including transitional support K-12; preparation in working with parents and families, community agencies, service providers, and support staff including paraeducators; strategies for working with general classroom teachers and knowledge of the collaborative and consultative roles of special education teachers in the integration of individuals with disabilities into the general curriculum and classroom; and special emphasis on transitions of students to postsecondary environments.

g. Assistive/instructional technology. To include preparation in the use of assistive and instructional technology to assist students with moderate to significant disabilities to access the core curriculum and address compensatory or individualized needs, including accessible instructional materials.

h. Student teaching across all grade levels (K-12) with students with disabilities.

14.2(11) *Special education specializations.* Specializations allow the applicant to demonstrate expanded knowledge and skills with specific disability categories. The following specializations are not endorsements and are not required for specific assignments, but may be used by local school districts and nonpublic schools in specific settings. Specializations may be added to a teaching license by the completion of an additional 15 credit hours dedicated to the specialization beyond the special education endorsement requirements.

a. Intellectual disabilities: Fifteen credit hours of coursework dedicated to characteristics, instructional methodology, assessment, and transition of K-12 students with intellectual disabilities.

b. Autism spectrum disorders: Fifteen credit hours of coursework dedicated to characteristics, instructional methodology, assessment, and transition of K-12 students with autism spectrum disorders.

c. Behavioral/emotional disorders: Fifteen credit hours of coursework dedicated to characteristics, instructional methodology, assessment, and transition of K-12 students with behavior/emotional disorders.

d. Multiple disabilities: Fifteen credit hours of coursework dedicated to characteristics, instructional methodology, assessment, and transition of K-12 students with multiple disabilities.

e. Physical disabilities: Fifteen credit hours of coursework dedicated to characteristics, instructional methodology, assessment, and transition of K-12 students with physical disabilities.

f. Learning disabilities: Fifteen credit hours of coursework dedicated to characteristics, instructional methodology, assessment, and transition of K-12 students with learning disabilities.

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¹ March 25, 2015, effective date of ARC 1884C [14.2(10), 14.2(11)] delayed until the adjournment of the 2016 General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2015.

CHAPTER 17
CAREER AND TECHNICAL ENDORSEMENTS AND LICENSES
[Prior to 1/14/09, see Educational Examiners[282] Ch 16]
Rescinded **ARC 2015C**, IAB 6/10/15, effective 7/15/15

CHAPTER 18
ISSUANCE OF ADMINISTRATOR LICENSES AND ENDORSEMENTS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

282—18.1(272) All applicants desiring an Iowa administrator license. Administrator licenses are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

18.1(1) *National criminal history background check.* An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

18.1(2) *Iowa division of criminal investigation background check.* An Iowa division of criminal investigation background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

18.1(3) *Temporary permits.* The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application, including certification from the applicant of completion of the Praxis II examination, if required; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check. The temporary permit shall serve as evidence of the applicant's authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check and the board's receipt of verification of completion of the Praxis II examination. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

282—18.2(272) Applicants from recognized Iowa institutions. Rescinded ARC 2016C, IAB 6/10/15, effective 7/15/15.

282—18.3(272) Applicants from recognized non-Iowa institutions. Rescinded IAB 9/9/09, effective 10/14/09.

282—18.4(272) General requirements for an administrator license.

18.4(1) *Eligibility for applicants who have completed a teacher preparation program.* Applicants for the administrator license must first comply with the requirements for all Iowa practitioners set out in 282—Chapter 13.

18.4(2) *Specific requirements for an initial administrator license for applicants who have completed a teacher preparation program.* An initial administrator license valid for one year may be issued to an applicant who:

- a. Has completed a state-approved PK-12 principal and PK-12 supervisor of special education program (see subrule 18.9(1)); and
- b. Has completed an evaluator approval program; and
- c. Provides a recommendation for the specific license and administrator endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed; and
- d. Has met the experience requirement set forth for the desired administrator endorsement; and
- e. Is not subject to any pending disciplinary proceedings in any state; and
- f. Complies with all requirements with regard to application processes and payment of licensure fees.

18.4(3) *Eligibility for applicants who have completed a professional service endorsement program.* Applicants for the administrator license must first comply with the requirements set out in 282—Chapter 27.

18.4(4) *Specific requirements for an initial administrator license for applicants who have completed a professional service endorsement.* An initial administrator license valid for one year may be issued to an applicant who:

- a. Is the holder of an Iowa professional service license; and
- b. Has three years of experience in an educational setting in the professional service endorsement area; and
- c. Has completed a state-approved PK-12 principal and PK-12 supervisor of special education program (see subrule 18.9(1)); and
- d. Is assuming a position as a PK-12 principal and PK-12 supervisor of special education (see subrule 18.9(1)) for the first time or has one year of out-of-state or nonpublic administrative experience; and
- e. Has completed the required coursework in human relations, cultural competency, diverse learners and reading instruction set forth in 281—subrules 79.15(2) and 79.15(3); and
- f. Has completed the professional education core in 281—paragraphs 79.15(5) “b” to “k”; and
- g. Has completed an evaluator approval program.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 8958B, IAB 7/28/10, effective 9/1/10; ARC 1326C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.5(272) Specific requirements for a professional administrator license. A professional administrator license valid for five years may be issued to an applicant who does all of the following:

18.5(1) Completes the requirements in 18.4(2) “a” to “g.”

18.5(2) Successfully meets each standard listed below:

a. *Shared vision.* An educational leader promotes the success of all students by facilitating the development, articulation, implementation, and stewardship of a vision of learning that is shared and supported by the school community. The administrator:

- (1) In collaboration with others, uses appropriate data to establish rigorous, concrete goals in the context of student achievement and instructional programs.
- (2) Uses research and best practices in improving the educational program.
- (3) Articulates and promotes high expectations for teaching and learning.
- (4) Aligns and implements the educational programs, plans, actions, and resources with the district’s vision and goals.
- (5) Provides leadership for major initiatives and change efforts.
- (6) Communicates effectively to various stakeholders regarding progress with school improvement plan goals.

b. *Culture of learning.* An educational leader promotes the success of all students by advocating, nurturing and sustaining a school culture and instructional program conducive to student learning and staff professional development. The administrator:

- (1) Provides leadership for assessing, developing and improving climate and culture.
- (2) Systematically and fairly recognizes and celebrates accomplishments of staff and students.
- (3) Provides leadership, encouragement, opportunities and structure for staff to continually design more effective teaching and learning experiences for all students.
- (4) Monitors and evaluates the effectiveness of curriculum, instruction and assessment.
- (5) Evaluates staff and provides ongoing coaching for improvement.
- (6) Ensures that staff members have professional development that directly enhances their performance and improves student learning.
- (7) Uses current research and theory about effective schools and leadership to develop and revise the administrator’s professional growth plan.
- (8) Promotes collaboration with all stakeholders.
- (9) Is easily accessible and approachable to all stakeholders.
- (10) Is highly visible and engaged in the school community.
- (11) Articulates the desired school culture and shows evidence about how it is reinforced.

c. Management. An educational leader promotes the success of all students by ensuring management of the organization, operations and resources for a safe, efficient and effective learning environment. The administrator:

- (1) Complies with state and federal mandates and local board policies.
- (2) Recruits, selects, inducts, and retains staff to support quality instruction.
- (3) Addresses current and potential issues in a timely manner.
- (4) Manages fiscal and physical resources responsibly, efficiently, and effectively.
- (5) Protects instructional time by designing and managing operational procedures to maximize learning.
- (6) Communicates effectively with both internal and external audiences about the operations of the school.

d. Family and community. An educational leader promotes the success of all students by collaborating with families and community members, responding to diverse community interests and needs, and mobilizing community resources. The administrator:

- (1) Engages family and community by promoting shared responsibility for student learning and support of the education system.
- (2) Promotes and supports a structure for family and community involvement in the education system.
- (3) Facilitates the connections of students and families to the health and social services that support a focus on learning.

18.5(3) Completes one year of administrative experience in an Iowa public school and completes the administrator mentoring program while holding an administrator license, or successfully completes two years of administrative experience in a nonpublic or out-of-state school setting.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 0607C, IAB 2/20/13, effective 3/27/13]

282—18.6(272) Specific requirements for an administrator prepared out of state. An applicant seeking Iowa licensure who completes an administrator preparation program from a recognized non-Iowa institution shall verify the requirements of rules 282—18.1(272) and 282—18.4(272) through traditional course-based preparation program and transcript review. A recognized non-Iowa administrator preparation institution is one that is state-approved and is accredited by the regional accrediting agency for the territory in which the institution is located. Applicants must hold and submit a copy of a valid or expired regular administrator certificate or license in the state in which the preparation was completed, exclusive of a temporary, emergency or substitute license or certificate.

18.6(1) Administrator exchange license. A one-year nonrenewable administrator exchange license may be issued to an individual who has not met any of the following requirements:

- a.* Professional core requirements. The applicant has not completed all of the required courses in the professional core in 281—subrules 79.15(2) and 79.15(3) and 281—paragraphs 79.15(5) “b” to “k.”
- b.* Endorsement requirements. The applicant has not completed a minimum of 75 percent of the coursework for the PK-12 principal and PK-12 supervisor of special education endorsement, and any additional administrator endorsements desired.
- c.* Regular administrator certificate or license in the state in which the preparation was completed. The applicant is eligible for and has applied for a regular administrator certificate or license in the state in which the preparation was completed but has not yet received the certificate or license.
- d.* Approved evaluator training requirement. The applicant has not completed the approved evaluator training requirement.

18.6(2) Conversion. Each applicant who receives the one-year administrator exchange license must complete any identified licensure deficiencies in order to be eligible for an initial administrator license or a professional administrator license in Iowa. Any coursework deficiencies must be completed for college credit through a regionally accredited institution, with the exception of the human relations component which may be taken for licensure renewal credit through an approved provider.

[ARC 8141B, IAB 9/9/09, effective 10/14/09; ARC 9383B, IAB 2/23/11, effective 3/30/11; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.7(272) Specific requirements for a Class A extension license.

18.7(1) A nonrenewable Class A extension license valid for one year may be issued to an applicant based on an expired Iowa professional administrator license. This license shall be endorsed for the type of service authorized by the expired license on which it is based.

18.7(2) The holder of an expired professional administrator license who is currently under contract with an Iowa educational unit (area education agency/local education agency/local school district) and who does not meet the renewal requirements for the administrator license held shall be required to secure the signature of the superintendent or designee before the Class A extension license will be issued. If the superintendent does not meet the renewal requirements, the superintendent shall be required to secure the signature of the school board president before the license will be issued.

[ARC 9384B, IAB 2/23/11, effective 3/30/11; ARC 9453B, IAB 4/6/11, effective 5/11/11; ARC 0564C, IAB 1/23/13, effective 2/27/13; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.8(272) Specific requirements for a Class B license. A nonrenewable Class B license valid for two years may be issued to an individual under the following conditions:

18.8(1) Endorsement in progress. The individual has a valid Iowa teaching license but is seeking to obtain an administrator endorsement. A Class B license may be issued if requested by an employer and the individual seeking this endorsement has completed at least 75 percent of the requirements leading to completion of all requirements for this endorsement.

18.8(2) Experience requirement.

a. Principal endorsement. For the principal endorsement, three years of teaching experience must have been met before application for the Class B license.

b. Superintendent endorsement. For the superintendent endorsement, three years of teaching experience and three years as a building principal or other PK-12 districtwide or intermediate agency experience are acceptable for becoming a superintendent, and must have been met before application for the Class B license.

18.8(3) Request for exception. Rescinded IAB 2/23/11, effective 3/30/11.
[ARC 9385B, IAB 2/23/11, effective 3/30/11]

282—18.9(272) Area and grade levels of administrator endorsements.

18.9(1) PK-12 principal and PK-12 supervisor of special education.

a. Authorization. The holder of this endorsement is authorized to serve as a principal of programs serving children from birth through grade twelve, a supervisor of instructional special education programs for children from birth to the age of 21, and a supervisor of support for special education programs for children from birth to the age of 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) Degree—master's.

(2) Content: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements.

1. Knowledge of early childhood, elementary, early adolescent and secondary level administration, supervision, and evaluation.

2. Knowledge and skill related to early childhood, elementary, early adolescent and secondary level curriculum development.

3. Knowledge of child growth and development from birth through adolescence and developmentally appropriate strategies and practices of early childhood, elementary, and adolescence, to include an observation practicum.

4. Knowledge of family support systems, factors which place families at risk, child care issues, and home-school community relationships and interactions designed to promote parent education, family involvement, and interagency collaboration.

5. Knowledge of school law and legislative and public policy issues affecting children and families.

6. Completion of evaluator training component.

7. Knowledge of current issues in special education administration.
 8. Planned field experiences in elementary and secondary school administration, including special education administration.

9. Competencies: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. A school administrator is an educational leader who promotes the success of all students by accomplishing the following competencies.

- Facilitates the development, articulation, implementation, and stewardship of a vision of learning that is shared and supported by the school community.

- Advocates, nurtures, and sustains a school culture and instructional program conducive to student learning and staff professional growth.

- Ensures management of the organization, operations, and resources for a safe, efficient, and effective learning environment.

- Collaborates with families and community members, responds to diverse community interests and needs, and mobilizes community resources.

- Acts with integrity, fairness, and in an ethical manner.

- Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.

c. *Other.*

(1) The applicant must have had three years of teaching experience at the early childhood through grade twelve level while holding a valid license.

(2) Graduates from out-of-state institutions who are seeking initial Iowa licensure and the PK-12 principal and PK-12 supervisor of special education endorsement must meet the requirements for the standard license in addition to the experience requirements.

18.9(2) PK-8 principal—out-of-state applicants. This endorsement is only for applicants from out-of-state institutions.

a. *Authorization.* The holder of this endorsement is authorized to serve as a principal of programs serving children from birth through grade eight.

b. *Program requirements.*

(1) Degree—master's.

(2) Content: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements.

1. Knowledge of early childhood, elementary, and early adolescent level administration, supervision, and evaluation.

2. Knowledge and skill related to early childhood, elementary, and early adolescent level curriculum development.

3. Knowledge of child growth and development from birth through early adolescence and developmentally appropriate strategies and practices of early childhood, elementary, and early adolescence, to include an observation practicum.

4. Knowledge of family support systems, factors which place families at risk, child care issues, and home-school community relationships and interactions designed to promote parent education, family involvement, and interagency collaboration.

5. Knowledge of school law and legislative and public policy issues affecting children and families.

6. Planned field experiences in early childhood and elementary or early adolescent school administration.

7. Completion of evaluator training component.

8. Competencies: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. A school administrator is an educational leader who promotes the success of all students by accomplishing the following competencies.

- Facilitates the development, articulation, implementation, and stewardship of a vision of learning that is shared and supported by the school community.

- Advocates, nurtures, and sustains a school culture and instructional program conducive to student learning and staff professional growth.
- Ensures management of the organization, operations, and resources for a safe, efficient, and effective learning environment.
- Collaborates with families and community members, responds to diverse community interests and needs, and mobilizes community resources.
- Acts with integrity, fairness, and in an ethical manner.
- Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.

c. Other. The applicant must have had three years of teaching experience at the early childhood through grade eight level while holding a valid license.

18.9(3) 5-12 principal—out-of-state applicants. This endorsement is only for applicants from out-of-state institutions.

a. Authorization. The holder of this endorsement is authorized to serve as a principal in grades five through twelve.

b. Program requirements.

(1) Degree—master’s.

(2) Content: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements.

1. Knowledge of early adolescent and secondary level administration, supervision, and evaluation.

2. Knowledge and skill related to early adolescent and secondary level curriculum development.

3. Knowledge of human growth and development from early adolescence through early adulthood, to include an observation practicum.

4. Knowledge of family support systems, factors which place families at risk, and home-school community relationships and interactions designed to promote parent education, family involvement, and interagency collaboration.

5. Knowledge of school law and legislative and public policy issues affecting children and families.

6. Planned field experiences in early adolescence or secondary school administration.

7. Completion of evaluator training component.

8. Competencies: Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. A school administrator is an educational leader who promotes the success of all students by accomplishing the following competencies.

- Facilitates the development, articulation, implementation, and stewardship of a vision of learning that is shared and supported by the school community.

- Advocates, nurtures, and sustains a school culture and instructional program conducive to student learning and staff professional growth.

- Ensures management of the organization, operations, and resources for a safe, efficient, and effective learning environment.

- Collaborates with families and community members, responds to diverse community interests and needs, and mobilizes community resources.

- Acts with integrity, fairness, and in an ethical manner.

- Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.

c. Other. The applicant must have had three years of teaching experience at the secondary level (5-12) while holding a valid license.

[ARC 0872C, IAB 7/24/13, effective 8/28/13; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.10(272) Superintendent/AEA administrator.

18.10(1) Authorization. The holder of this endorsement is authorized to serve as a superintendent from the prekindergarten level through grade twelve or as an AEA administrator. NOTE: This

authorization does not permit general teaching, school service, or administration at any level except that level or area for which the practitioner holds the specific endorsement(s).

18.10(2) Program requirements.

a. Degree—specialist (or its equivalent: A master’s degree plus at least 30 semester hours of planned graduate study in administration beyond the master’s degree).

b. Content. Through completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements, the administrator has knowledge and understanding of:

(1) Models, theories, and practices that provide the basis for leading educational systems toward improving student performance.

(2) Federal, state and local fiscal policies related to education.

(3) Human resources management, including recruitment, personnel assistance and development, evaluation and negotiations.

(4) Current legal issues in general and special education.

(5) Noninstructional support services management including but not limited to transportation, nutrition and facilities.

(6) Practicum in PK-12 school administration. In the coursework and the practicum, the administrator facilitates processes and engages in activities for:

1. Developing a shared vision of learning through articulation, implementation, and stewardship.

2. Advocating, nurturing, and sustaining a school culture and instructional program conducive to student learning and staff professional growth.

3. Ensuring management of the organization, operations, and resources for a safe, efficient, and effective learning environment.

4. Collaborating with school staff, families, community members and boards of directors; responding to diverse community interests and needs; and mobilizing community resources.

5. Acting with integrity, fairness, and in an ethical manner.

6. Understanding, responding to, and influencing the larger political, social, economic, legal, and cultural context.

18.10(3) Administrative experience. The applicant must meet one of the following:

a. The applicant must have had three years of experience as a building principal while holding a valid license.

b. The applicant must have three years of administrative experience in any of the following areas: PK-12 regional education agency administrative experience, PK-12 state department of education administrative experience, PK-12 educational licensing board administrative experience or PK-12 building/district administrative experience while holding a valid Iowa administrator license.

c. The applicant must have six years of teaching and administrative experience, provided that at least two years are teaching experience and one year is administrative experience, all while holding a valid license.

[ARC 8248B, IAB 11/4/09, effective 10/12/09; ARC 0872C, IAB 7/24/13, effective 8/28/13; ARC 1167C, IAB 11/13/13, effective 12/18/13; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.11(272) Director of special education of an area education agency.

18.11(1) Authorization. The holder of this endorsement is authorized to serve as a director of special education of an area education agency. Assistant directors are also required to hold this endorsement.

18.11(2) Program requirements.

a. Degree—specialist or its equivalent. An applicant must hold a master’s degree plus at least 32 semester hours of planned graduate study in administration or special education beyond the master’s degree.

b. Endorsement. An applicant must hold or meet the requirements for one of the following:

(1) PK-12 principal and PK-12 supervisor of special education (see rule 282—18.9(272));

(2) Supervisor of special education—instructional (see rule 282—15.5(272));

(3) Professional service administrator (see 282—subrule 27.3(5)); or

- (4) A letter of authorization for special education supervisor issued prior to October 1, 1988.
- c. Content.* An applicant must have completed a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements to include the following:
- (1) Knowledge of federal, state and local fiscal policies related to education.
 - (2) Knowledge of school plant/facility planning.
 - (3) Knowledge of human resources management, including recruitment, personnel assistance and development, evaluations and negotiations.
 - (4) Knowledge of models, theories and philosophies that provide the basis for educational systems.
 - (5) Knowledge of current issues in special education.
 - (6) Knowledge of special education school law and legislative and public policy issues affecting children and families.
 - (7) Knowledge of the powers and duties of the director of special education of an area education agency as delineated in Iowa Code section 273.5.
 - (8) Practicum in administration and supervision of special education programs.
- d. Experience.* An applicant must have three years of administrative experience as a PK-12 principal or PK-12 supervisor of special education.
- e. Competencies.* Through completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements, the director of special education accomplishes the following:
- (1) Facilitates the development, articulation, implementation and stewardship of a vision of learning that is shared and supported by the school community.
 - (2) Advocates, nurtures and sustains a school culture and instructional program conducive to student learning and staff professional growth.
 - (3) Ensures management of the organization, operations and resources for a safe, efficient and effective learning environment.
 - (4) Collaborates with educational staff, families and community members; responds to diverse community interests and needs; and mobilizes community resources.
 - (5) Acts with integrity and fairness and in an ethical manner.
 - (6) Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.
 - (7) Collaborates and assists in supporting integrated work of the entire agency.

18.11(3) Other.

a. Option 1: Instructional. An applicant must meet the requirements for one special education teaching endorsement and have three years of teaching experience in special education.

b. Option 2: Support. An applicant must meet the practitioner licensure requirements for one of the following endorsements and have three years of experience as a:

- (1) School audiologist;
- (2) School psychologist;
- (3) School social worker; or
- (4) Speech-language pathologist.

NOTE: An individual holding a statement of professional recognition is not eligible for the director of special education of an area education agency endorsement.

[ARC 9075B, IAB 9/8/10, effective 10/13/10]

282—18.12(272) Specific requirements for a Class E emergency license. A nonrenewable Class E emergency license valid for one year may be issued to an individual as follows.

18.12(1) Expired license. Based on an expired Class A, Class B, or administrator exchange license, the holder of the expired license shall be eligible to receive a Class E license upon application and submission of all required materials.

18.12(2) Application. The application process will require transcripts of coursework completed during the term of the expired license, a program of study indicating the coursework necessary to obtain full licensure, and registration for coursework to be completed during the term of the Class E license.

The Class E license will be denied if the applicant has not completed any coursework during the term of the Class A, Class B, or administrator exchange license unless extenuating circumstances are verified. [ARC 0874C, IAB 7/24/13, effective 8/28/13; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—18.13 Reserved.

282—18.14(272) Endorsements.

18.14(1) After the issuance of an administrator license, an individual may add other administrator endorsements to that license upon proper application, provided current requirements for that endorsement, as listed in rules 282—18.9(272) through 282—18.11(272), have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

18.14(2) The applicant must follow one of these options:

- a. Identify with a recognized Iowa administrator preparing institution, meet that institution's current requirements for the endorsement desired, and receive that institution's recommendation; or
- b. Identify with a recognized non-Iowa administrator preparation institution and receive a statement that the applicant has completed the equivalent of the institution's approved program for the endorsement sought.

282—18.15(272) Licenses—issue dates, corrections, duplicates, and fraud.

18.15(1) *Issue date on original license.* A license is valid only from and after the date of issuance.

18.15(2) *Correcting licenses.* If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

18.15(3) *Duplicate licenses.* Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

18.15(4) *Fraud in procurement or renewal of licenses.* Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 2016C (Notice ARC 1918C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]

CHAPTER 19
EVALUATOR ENDORSEMENT AND LICENSE
[Prior to 1/14/09, see Educational Examiners Board[282] Ch 20]

These rules are to accompany rule 281—83.5(284), Evaluator Approval Training, adopted by the department of education.

282—19.1(272) Evaluator endorsement and license. This endorsement or this license authorizes services as required by Iowa Code section 284.10.

282—19.2(272) Initial evaluator endorsement. To obtain this authorization as an endorsement on an administrator, evaluator, or teaching license, an applicant must complete the requirements as specified in 281—83.5(284).

282—19.3(272) Evaluator endorsement. The requirements for the evaluator endorsement shall be included in each program leading to administrator licensure and administrator endorsements in Iowa colleges and universities approved to offer these programs.

282—19.4(272) Applicants for administrator licensure. Each applicant for an initial administrator license shall have completed the evaluator endorsement requirements.

282—19.5(272) Evaluator license. Applicants may apply for the five-year evaluator license upon completion of the evaluator training required in Iowa Code section 284.10.

282—19.6(272) Out-of-state applicants. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—19.7(272) Renewal of administrator licenses.

19.7(1) Each applicant for renewal of an administrator license shall have completed the evaluator endorsement requirements.

19.7(2) Extension of an administrator license:

a. May be granted to an applicant who has not completed the new evaluator renewal training course before the expiration date on the applicant's license; and

b. May be granted for a one-year period.

[**ARC 0451C**, IAB 11/14/12, effective 12/19/12; **ARC 0873C**, IAB 7/24/13, effective 8/28/13]

282—19.8(272) Renewal of evaluator endorsement or license. Coursework for renewal of the evaluator license or the license with the evaluator endorsement must complement the initial requirements. This coursework, approved by the Iowa department of education, must be completed for at least one semester hour of college or university credit or for at least one renewal unit from an approved Iowa staff development program.

19.8(1) *Child and dependent adult abuse training.* All applicants renewing an evaluator license must submit documentation of completion of the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply if a person submits appropriate documentation of any of the following:

a. A person is engaged in active duty in the military service of this state or of the United States.

b. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.

c. A person is practicing a licensed profession outside this state.

d. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

19.8(2) *Conversion.* An individual holding the evaluator license may convert this license to an endorsement at the time of renewal. The fee for this conversion process will equal the fee for license renewal. The endorsement will be placed on the administrator or teaching license.

282—19.9(272) Holder of permanent professional certificate. The holder of the permanent professional certificate with an administrator endorsement must hold a valid evaluator license if the person serves as an administrator who evaluates licensed personnel. The holder of the permanent professional certificate with an administrator endorsement cannot use the option in subrule 19.8(2).

282—19.10(272) Licenses—issue dates, corrections, duplicates, and fraud.

19.10(1) *Issue date on original license.* A license is valid only from and after the date of issuance.

19.10(2) *Correcting licenses.* If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

19.10(3) *Duplicate licenses.* Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

19.10(4) *Fraud in procurement or renewal of licenses.* Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

These rules are intended to implement Iowa Code chapter 272.

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[Filed ARC 0451C (Notice ARC 0311C, IAB 9/5/12), IAB 11/14/12, effective 12/19/12]

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CHAPTER 20
RENEWALS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 17]

282—20.1(272) General renewal information. This chapter contains renewal requirements for those individuals desiring to renew the initial, standard, master educator, professional administrator, area education agency administrator, or substitute license or a statement of professional recognition (SPR). Individuals desiring to renew a license issued under some other title are referred to 282—Chapters 22, 23, and 24.

282—20.2(272) Renewal application forms. Application forms for renewal may be obtained from the board of educational examiners' Web site at www.boee.iowa.gov or by contacting the office at (515)281-3245.

282—20.3(272) Renewal of licenses.

20.3(1) Issue date. A renewed license is valid only from and after the date of issuance.

20.3(2) General renewal requirements. A license may be renewed for applicants who fulfill the general requirements set out in subrules 20.3(3) through 20.3(5) and the license-specific requirements set out in this chapter under each license.

20.3(3) Background check. Every renewal applicant is required to submit a completed application form with the applicant's signature to facilitate a check of the sex offender registry information under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, and the dependent adult abuse records maintained under Iowa Code chapter 235B. The board may assess the applicant a fee no greater than the costs associated with obtaining and evaluating the background check.

20.3(4) Child and dependent adult abuse training. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

- a. A person is engaged in active duty in the military service of this state or of the United States.
- b. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.
- c. A person is practicing a licensed profession outside this state.
- d. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

20.3(5) Recency of units for renewal. If a license is renewed on or before the date of expiration, the units for renewal are acceptable if earned during the term of the license. If a license is not renewed on the date of expiration, the units for renewal must have been completed within the five-year period immediately preceding the date of application for the renewal.

20.3(6) Timely renewal. A license may only be renewed less than one year before it expires.
[ARC 9451B, IAB 4/6/11, effective 5/11/11; ARC 0026C, IAB 3/7/12, effective 4/11/12]

282—20.4(272) Specific renewal requirements for the initial license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272). If a person meets all requirements for the standard license except for the options required in rule 282—13.7(272), paragraph "2," the initial license may be renewed upon written request. A second renewal may be granted if the holder of the initial license has not met the options required in rule 282—13.7(272), paragraph "2," and if the license holder can provide evidence of teaching employment which will be acceptable for the experience requirement. A Class A license may be issued instead of the renewal of the initial license for another initial license if the applicant verifies one of the following:

1. The applicant is involved in the second year of the mentoring and induction program, but the license will expire before the second year of teaching is completed.

2. The applicant has taught for two years in a nonpublic school setting and needs one additional year of teaching to convert the initial license to the standard license.
[ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—20.5(272) Specific renewal requirements for the standard license.

20.5(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.5(2) Six units are needed for renewal. These units may be earned in any combination listed as follows:

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

e. Four units may be earned for successful completion of the National Board for Professional Teaching Standards certification. This certification may be used one time for either the standard or the master educator license.

f. One unit may be earned upon successful acquisition of three points from the following activities:
(1) Mentoring a full-semester student teacher (12 or more weeks) is worth two points.
(2) Mentoring a half-semester student teacher (less than 12 weeks) is worth one point.
(3) Mentoring a practicum student or practicum students (early field experience) equivalent to 60 contact hours (hours may be accrued over several semesters) is worth one point.

(4) Attending (from start to finish) a cooperating teachers' workshop in conjunction with mentoring a student teacher or practicum student is worth one point.

(5) Serving as a multiyear member of a teacher education program's advisory committee is worth one point.

282—20.6(272) Specific renewal requirements for a master educator license.

20.6(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.6(2) Four units are needed for renewal. These units may be earned in any combination listed below:

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

e. Four units may be earned upon successful completion of the National Board for Professional Teaching Standards certification. This certification may be used one time for either the standard or the master educator license.

- f.* One unit may be earned upon successful acquisition of three points from the following activities:
- (1) Mentoring a full-semester student teacher (12 or more weeks) is worth two points.
 - (2) Mentoring a half-semester student teacher (less than 12 weeks) is worth one point.
 - (3) Mentoring a practicum student or practicum students (early field experience) equivalent to 60 contact hours (hours may be accrued over several semesters) is worth one point.
 - (4) Attending (from start to finish) a cooperating teachers' workshop in conjunction with mentoring a student teacher or practicum student is worth one point.
 - (5) Serving as a multiyear member of a teacher education program's advisory committee is worth one point.

282—20.7(272) Specific renewal requirements for a substitute license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272). An applicant for renewal of a substitute license shall meet one of the requirements listed below:

1. Verification of at least 30 days of substitute teaching during the term of the license or one year of teaching experience within the last five years completed during the term of a valid Iowa teaching license.
2. Completion of a local education agency or area education agency course approved through licensure renewal guidelines established by the board of educational examiners.
3. Completion of one semester hour of credit taken from a community college, college, or university.

[ARC 7988B, IAB 7/29/09, effective 9/2/09]

282—20.8(272) Specific renewal requirements for the initial administrator license. In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.8(1) Requirements. If an applicant meets all requirements for the professional administrator license except for the requirements in 282—subrule 18.4(1), the initial administrator license may be renewed upon written request. A second renewal may be granted if the holder of the initial administrator license has not met the requirements in 282—subrule 18.4(1) and if the license holder can provide evidence of employment as a PK-12 administrator, which meets the experience requirement.

20.8(2) Extension. An extension of the initial administrator license may be issued instead of the renewal of the initial administrator license if the applicant verifies one of the following:

- a.* The applicant is involved in a mentoring and induction program, but the license will expire before the first year of administrative experience is completed.
- b.* The applicant has one year of administrative experience in a nonpublic school setting or in an out-of-state setting and needs one additional year of administrative experience to convert the initial license to the professional license.

[ARC 2017C, IAB 6/10/15, effective 7/15/15]

282—20.9(272) Specific renewal requirements for an administrator license.

20.9(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

20.9(2) Four units are needed for renewal. These units may be earned in any combination listed below.

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned specialist's or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an administrator endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved through guidelines established by the board of educational examiners.

20.9(3) Evaluator training. An applicant renewing an administrator license must submit documentation of completion of the evaluator training required in Iowa Code section 284.10. A waiver of the evaluator training may apply under the following conditions with appropriate documentation of any of the following:

- a.* The person is engaged in active duty in the military service of this state or of the United States.
- b.* The application of the evaluator training would impose an undue hardship on the person for whom the waiver is requested.
- c.* The person is practicing in a licensed profession outside this state.

282—20.10(272) Renewal requirements for a statement of professional recognition (SPR).

20.10(1) Renewal of the SPR.

- a.* The applicant must:
 - (1) Apply for renewal every five years.
 - (2) Maintain continual licensure with the board with which the applicant holds other licensure.
 - (3) Complete continuing education as required by the board with which the applicant holds other licensure.
- b.* The SPR shall be valid for five years.
- c.* The fee for issuance of the SPR certificate shall be the same as for a standard license as set forth in 282—Chapter 12. All fees are nonrefundable.

20.10(2) Each applicant renewing an SPR must provide documentation that all renewal requirements in subrules 20.3(1) through 20.3(4) have been met.

282—20.11(272) Audit of applications for license renewal. The board will randomly audit a minimum of 10 percent of the applications for renewal of the standard, master educator, and administrator licenses.

20.11(1) *Verification required.* If audited, the licensee must submit verification of compliance with renewal credit requirements. Licensees are required to keep transcripts of courses taken during the term of the license. Original transcripts and all other documents as required by 282—Chapter 20 must be submitted within 30 calendar days after the date of the audit. An extension of time may be granted on an individual basis.

20.11(2) *Results of audit.*

- a.* The board shall notify the licensee of satisfactory completion of the audit by issuing the license.
- b.* A licensee's failure to complete the audit satisfactorily or falsification of information shall be considered a violation of 282—Chapter 25, Code of Professional Conduct and Ethics, and the executive director may initiate a complaint against the licensee.
- c.* A licensee's failure to notify the board of a current mailing address will not absolve the licensee from the audit requirement; completion of an audit will be required prior to further license renewal.

282—20.12(272) Appeal procedure. Any teacher seeking a different level of license who is denied the license due to the evaluation or other requirements may appeal the decision. The appeal shall be made in writing to the executive director of the board of educational examiners who shall establish a date for the hearing within 20 days of receipt of written notice of appeal by giving five days' written notice to appellant unless a shorter time is mutually agreeable. The procedures for hearing followed by the board of educational examiners shall be applicable.

282—20.13(272) Licensure renewal programs.

20.13(1) *Application process.* These rules are to be followed in the preparation and submission of proposals for licensure renewal programs. The application materials must be returned to the board of educational examiners for review and approval. Once the application has been submitted, it will be reviewed, and the applicant agency will be notified of approval or nonapproval and any deficiencies.

20.13(2) *Application for licensure renewal program.*

a. The application shall contain evidence that the local board of directors (the boards of directors in consortium-based applications) has given formal approval to the development and implementation of the program and the allocation of program resources.

b. The application shall identify the criteria used in selecting faculty/instructors for the licensure renewal programs. These criteria shall include qualifications, experiences (relevant to the nature of the program), preparation and licensure status.

c. There must be evidence of a current survey using multiple data sources that includes, but is not limited to, district and building school improvement goals as well as staff needs and an explanation of procedures used to derive such needs; this documentation must be furnished as a part of the application for a licensure renewal program.

d. Programs developed by eligible agencies shall be based on evidence gathered from the survey referenced in paragraph "c" above.

e. Program objectives must be derived from identified educational needs in the district or districts or special groups to be served; these objectives shall be developed by the eligible agency seeking approval under licensure renewal programs.

f. Each application must include procedures for program evaluation; this evaluation must include faculty/instructor as well as course/activity evaluation. Program and course/activity evaluation shall include, but not be limited to, participant perceptions.

g. Evaluation. The evaluation shall include participant perception and, whenever possible, observation data collection techniques and analyses are required for each approved licensure renewal program.

20.13(3) *Eligible agencies/institutions.*

a. Teacher renewal.

- (1) Area education agencies, local education agencies, individually or in consortium arrangements.
- (2) Approved nonpublic districts, individually or in consortium arrangements.
- (3) Iowa educational professional organizations.
- (4) Iowa colleges and universities approved for teacher education.

b. Administrator renewal.

- (1) Area education agencies, local education agencies, individually or in consortium arrangements.
- (2) Approved nonpublic districts, individually or in consortium arrangements.
- (3) Iowa educational professional organizations.
- (4) Iowa colleges and universities approved for teacher education.

20.13(4) *Authority.* The acceptance of licensure renewal credit is provided in rules 282—20.5(272), 282—20.6(272), and 282—20.9(272).

20.13(5) *Licensure renewal courses.*

a. Licensure renewal courses are planned experiences, activities, and studies designed to develop skills, techniques, knowledge, and understanding of educational research and best practice and to model best practices in professional and organizational development. These courses support school improvement processes and practices and provide for the development of leadership in education. Approved courses and programs must be designed to follow the terms of the renewal requirements set forth for teacher and administrator license renewal in rules 282—20.5(272), 282—20.6(272), and 282—20.9(272). The following indicators of quality will be used in evaluating the approved license renewal programs:

(1) The courses address specific student, teacher, and school needs evidenced in local school improvement plans; or

(2) The courses assist teachers in improving student learning; or

(3) The courses assist teachers in improving teaching evidenced through the adoption or application of practices, strategies, and information.

b. Approved teacher licensure renewal programs must offer and conduct a minimum of ten different courses for teachers during the calendar year, and approved administrator licensure renewal programs must conduct a minimum of five different courses for administrators during the calendar year.

c. A minimum of 15 scheduled clock hours of contact with the instructor, study groups or action research teams equal one renewal unit. Only whole units may be submitted to the board of educational examiners for license renewal.

d. Only renewal units offered through board of educational examiners-approved licensure renewal programs will be accepted for license renewal.

20.13(6) Licensure renewal advisory committee. Licensure renewal programs must be developed with the assistance of a licensure renewal advisory committee.

a. *Membership of the advisory committee.* Once the advisory committee is established, matters pertaining to the term of membership shall be spelled out through established procedures. The advisory committee shall consist of no fewer than five members. The licensure renewal coordinator shall forward the current updated list of licensure renewal advisory committee members to the board of educational examiners upon request.

(1) The licensure renewal advisory committee shall include the following persons for teacher/administrator renewal programs:

1. Elementary and secondary classroom teachers.

2. Local administrators: elementary or secondary principals, curriculum director or superintendent.

3. Higher education representative from a college or university offering an approved teacher education program.

4. Other categories may also be appointed: community college teaching faculty, students, area education agency staff members, school board members, members of educational professional organizations, business/industry representatives, community representatives, representatives of substitute teachers.

(2) The make-up of the membership should reflect the ratio of teachers to administrators within an agency or organization offering an approved licensure renewal program. The membership should reflect the general population by a balance of gender and race and shall be balanced between urban and rural districts.

(3) The licensure renewal coordinator shall be a nonvoting advisory committee member.

(4) Disputes about the appropriate composition of the membership of the licensure renewal advisory committee shall be resolved through local committee action.

b. *Responsibilities of licensure renewal advisory committee.* The licensure renewal advisory committee shall be involved in:

(1) The ongoing area education agency, local district, or other agency staff development needs assessment.

(2) The design and development of an original application for a license renewal program.

(3) The development of criteria for the selection of course instructors; and these criteria shall include, but not be limited to, academic preparation, experience and certification status.

(4) The annual evaluation of licensure renewal programs.

20.13(7) Licensure renewal coordinator.

a. Each agency or organization offering an approved licensure renewal program shall identify a licensed (elementary or secondary) professional staff member who shall be designated as coordinator for the program. This function must be assigned; no application will be approved unless this function has been assigned.

b. Responsibilities of licensure renewal coordinators:

(1) File all reports as requested by the board of educational examiners.

(2) Serve as a contact person for the board of educational examiners.

(3) Be responsible for the development of licensure renewal programs which address the professional growth concerns of the clientele.

(4) Be responsible for the approval of all courses or units offered for licensure renewal.

(5) Maintain records of approved courses as conducted and of the names of the qualifying participants.

(6) Maintain a list of all course offerings and approved instructors and forward the list to the board of educational examiners.

(7) Provide a record of credit for each participant and maintain a cumulative record of credits earned for each participant for a minimum of ten years.

(8) Be responsible for informing participants of the reporting procedures for renewal credits/units earned.

20.13(8) Organization and administration.

a. Local school districts are encouraged to work cooperatively with their respective area education agency in assessing needs and designing and conducting courses.

b. The board of educational examiners reserves the right to evaluate any course, to require submission of evaluation data and to conduct sufficient on-site evaluation to ensure high quality of licensure renewal programs.

c. Agencies or institutions developing new programs shall submit a letter of intent prior to the submission of an application. The application must be filed at least three months prior to the initiation of any planned licensure renewal program.

d. Once a program is approved, the coordinator shall approve all course offerings for licensure renewal units.

e. Initial approval may be for one to three years. Continuing approval may be granted for five-year terms. Continuing approval may involve board of educational examiners sponsored team visits.

f. Records retention. Each approved staff development agency/institution shall retain program descriptions, course activities, documentation of the qualifications of delivery personnel, evaluation reports, and completed renewal units for a period of ten years. This information shall be kept on file in the offices of the area education agency licensure renewal coordinators and shall be made available to the board of educational examiners upon request.

g. Monitoring and evaluation. Each approved licensure renewal program will be monitored by the board of educational examiners to determine the extent to which the program meets/continues to meet program standards and is moving toward the attainment of program objectives. This will include an annual report which shall include an annotated description of the courses provided, evidence of the collaborative efforts used in developing the courses, evidence of the intended results of the courses, and the data for demonstrating progress toward the intended results.

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 22
AUTHORIZATIONS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 19]

282—22.1(272) Coaching authorization. A coaching authorization allows an individual to coach any sport in a middle school, junior high school, or high school.

22.1(1) Application process. Any person interested in the coaching authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at <http://www.boee.iowa.gov/>, or from institutions or agencies offering approved courses or contact hours.

22.1(2) Requirements. Applicants for the coaching authorization shall have completed the following requirements:

a. Credit hours. Applicants must complete credit hours in the following areas:

(1) Successful completion of 1 semester credit hour or 10 contact hours in a course relating to knowledge and understanding of the structure and function of the human body in relation to physical activity.

(2) Successful completion of 1 semester credit hour or 10 contact hours in a course relating to knowledge and understanding of human growth and development of children and youth in relation to physical activity.

(3) Successful completion of 2 semester credit hours or 20 contact hours in a course relating to knowledge and understanding of the prevention and care of athletic injuries and medical and safety problems relating to physical activity.

(4) Successful completion of 1 semester credit hour or 10 contact hours relating to knowledge and understanding of the techniques and theory of coaching interscholastic athletics.

(5) Beginning on or after July 1, 2000, each applicant for an initial coaching authorization shall have successfully completed 1 semester credit hour or 15 contact hours in a course relating to the theory of coaching which must include at least 5 contact hours relating to the knowledge and understanding of professional ethics and legal responsibilities of coaches.

(6) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

b. Minimum age. Applicants must have attained a minimum age of 18 years.

c. Iowa division of criminal investigation background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.

d. National criminal history background check. Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

22.1(3) Validity. The coaching authorization shall be valid for five years.

22.1(4) Renewal. The authorization may be renewed upon application and verification of successful completion of:

a. Renewal activities. Applicants for renewal of a coaching authorization must:

(1) Successfully complete five planned renewal activities/courses related to athletic coaching approved in accordance with guidelines approved by the board of educational examiners. Additionally, each applicant for the renewal of a coaching authorization shall have completed one renewal activity/course relating to the knowledge and understanding of professional ethics and legal responsibilities of coaches.

(2) Annually complete the concussion training approved by the Iowa High School Athletic Association or the Iowa Girls High School Athletic Union. Completion of the concussion training may be waived if the applicant is not serving as a coach. Attendance at the annual concussion training may be used for a maximum of one planned activity/course required in 22.1(4)“a”(1).

(3) Complete child and dependent adult abuse training. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse training approved by the state abuse

education review panel. This certification may be used for a maximum of one planned activity/course required in 22.1(4)“a”(1). A waiver of this requirement may apply if a person is engaged in active duty in the military service of this state or of the United States.

b. A one-year extension of the applicant’s coaching authorization may be issued if all requirements for the renewal of the coaching authorization have not been met. The applicant must complete the concussion training approved by the Iowa High School Athletic Association or the Iowa Girls High School Athletic Union before serving as a coach. The one-year extension is not renewable. The fee for this extension is found in 282—Chapter 12.

22.1(5) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the coaching authorization. An ethics complaint may be filed if a practitioner begins coaching a sport without current concussion training.

22.1(6) *Approval of courses.* Each institution of higher education, private college or university, merged area school or area education agency wishing to offer the semester credit or contact hours for the coaching authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 0866C, IAB 7/24/13, effective 8/28/13]

282—22.2(272) *Substitute authorization.* A substitute authorization allows an individual to substitute in grades PK-12 for no more than 5 consecutive days and no more than 10 days in a 30-day period in one job assignment for a regularly assigned teacher who is absent, except in the driver’s education classroom. A school district administrator may file a written request with the board for an extension of the 10-day limit in one job assignment on the basis of documented need and benefit to the instructional program. The licensure committee will review the request and provide a written decision either approving or denying the request. An individual who holds a paraeducator certificate without a bachelor’s degree and completes the substitute authorization program is authorized to substitute only in the special education classroom in which the individual paraeducator is employed.

22.2(1) *Application process.* Any person interested in the substitute authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at <http://www.boee.iowa.gov/> or from institutions or agencies offering approved courses or contact hours.

a. Requirements. Applicants for the substitute authorization shall meet the following requirements:

(1) Authorization program. Applicants must complete a board of educational examiners-approved substitute authorization program consisting of the following components and totaling a minimum of 15 clock hours:

1. Classroom management. This component includes an understanding of individual and group motivation and behavior to create a learning environment that encourages positive social interaction, active engagement in learning, and self-motivation.

2. Strategies for learning. This component includes understanding and using a variety of learning strategies to encourage students’ development of critical thinking, problem solving, and performance skills.

3. Diversity. This component includes understanding how students differ in their approaches to learning and creating learning opportunities that are equitable and are adaptable to diverse learners.

4. Ethics. This component includes fostering relationships with parents, school colleagues, and organizations in the larger community to support students’ learning and development and to be aware of the board’s rules of professional practice and competent performance.

(2) Degree or certificate. Applicants must have achieved at least one of the following:

1. Hold a baccalaureate degree from a regionally accredited institution.

2. Completed an approved paraeducator certification program and hold a paraeducator certificate.

(3) Minimum age. Applicants must have attained a minimum age of 21 years.

(4) Iowa division of criminal investigation background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.

(5) National criminal history background check. Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

b. Validity. The substitute authorization shall be valid for three years.

c. Renewal. The authorization may be renewed upon application and verification of successful completion of:

(1) Renewal units. Applicants for renewal of the substitute authorization must provide verification of a minimum of two semester hours of renewal credits.

(2) Child and dependent adult abuse training. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

1. A person is engaged in active duty in the military service of this state or of the United States.

2. The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.

3. A person is practicing a licensed profession outside this state.

4. A person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.

5. The person has previously renewed a license or another authorization issued by the board of educational examiners and, at that time, reported the completion, within the past five years, of child and dependent adult abuse training approved by the state abuse education review panel.

22.2(2) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the substitute authorization.

22.2(3) Approval of courses. Each institution of higher education, private college or university, merged area school or area education agency wishing to offer the semester credit or contact hours for the substitute authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 7745B, IAB 5/6/09, effective 6/10/09; ARC 0865C, IAB 7/24/13, effective 8/28/13; ARC 1087C, IAB 10/16/13, effective 11/20/13; ARC 1720C, IAB 11/12/14, effective 12/17/14]

282—22.3(272) School business official authorization.

22.3(1) Application for authorization. Effective July 1, 2012, a person who is interested in a school business official authorization will be required to apply for an authorization.

22.3(2) Responsibilities. A school business official authorization allows an individual to perform, supervise, and be responsible for the overall financial operation of a local school district.

22.3(3) Application process. Any person interested in the school business official authorization shall submit records of credit to the board of educational examiners for an evaluation in terms of the required courses or contact hours. Application materials are available from the office of the board of educational examiners, online at <http://www.boee.iowa.gov/>, or from institutions or agencies offering approved courses or contact hours.

22.3(4) Specific requirements for an initial school business official authorization. Applicants for an initial school business official authorization shall have completed the following requirements:

a. Education. Applicants must have a minimum of an associate's degree in business or accounting or 60 semester hours of coursework in business or accounting of which 9 semester hours must be in accounting.

If the applicant has not completed 9 semester hours in accounting but has 6 or more semester hours in accounting, the applicant may be issued a temporary school business official authorization valid for one year.

(1) A temporary initial school business official authorization may be issued if requested by the district. A district administrator may file a written request with the executive director for an exception to the minimum content requirements on the basis of documented need and benefit to the district. The executive director will review the request and provide a written decision either approving or denying the request.

(2) If the 9 semester hours of accounting are not completed within the time allowed, the applicant will not be eligible for the initial school business official authorization.

(3) If the applicant received a temporary school business official authorization, then the initial school business official authorization shall not exceed one year.

b. Minimum age. Applicants must have attained a minimum age of 18 years.

c. Iowa division of criminal investigation background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.

d. National criminal history background check. Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

22.3(5) Specific requirements for a standard school business official authorization.

a. A standard school business official authorization will be valid for three years and may be issued to an applicant who meets the requirements set forth in subrules 22.3(3) to 22.3(5).

b. Requirements.

(1) Applicants must complete 9 semester hours or the equivalent (1 semester hour is equivalent to 15 contact hours) in an approved program in the following areas/competencies:

1. Accounting (GAAP) concepts: fund accounting, account codes, Uniform Financial Accounting.

2. Accounting cycles: budgets, payroll/benefits, purchasing/inventory, cash, receipts, disbursements, financial reporting, investments.

3. Technology: management of accounting systems, proficiency in understanding and use of systems technology and related programs.

4. Regulatory: Uniform Administrative Procedures Manual, school policies and procedures, administrative procedures, public records law, records management, school law, employment law, construction and bidding law.

5. Personal skills: effective communication and interpersonal skills, ethical conduct, information management, ability to analyze and evaluate, ability to recognize and safeguard confidential information, and accurate and timely performance.

(2) Applicants shall demonstrate completion of or competency in the following:

1. A board of educational examiners ethics program.

2. A mentoring program as described in 281—Chapter 81.

3. The promotion of the value of the school business official's fiduciary responsibility to the taxpayer.

22.3(6) Validity.

a. The initial school business official authorization shall be valid for two years from the date of issuance.

b. The standard school business official authorization shall be valid for three years, and it shall expire three years from the date of issuance on the last day of the practitioner's birth month.

22.3(7) Renewal. The authorization may be renewed upon application and verification of successful completion of:

a. Renewal activities.

(1) In addition to the child and dependent adult abuse mandatory reporter training listed below, the applicant for renewal must complete 4 semester hours of credit or the equivalent contact hours (1 semester hour is equivalent to 15 contact hours) within the three-year licensure period.

(2) Failure to complete requirements for renewal will require a petition for waiver from the board.

b. Child and dependent adult abuse mandatory reporter training. Every renewal applicant must submit documentation of completion of the child and dependent adult abuse mandatory reporter training

approved by the state abuse education review panel. A waiver of this requirement may apply under any of the following appropriately documented conditions:

- (1) The person is engaged in active duty in the military service of this state or of the United States.
- (2) The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.
- (3) The person is practicing in a licensed profession outside this state.
- (4) The person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse mandatory reporter training in this state.
- (5) The person has previously renewed a license or another authorization issued by the board of educational examiners and, at that time, reported the completion, within the past five years, of child and dependent adult abuse mandatory reporter training approved by the state abuse education review panel.

22.3(8) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the school business official authorization.

22.3(9) *Approval of courses.* Each institution of higher education, private college or university, merged area school or area education agency and professional organization that wishes to offer the semester credit hours or contact hours for the school business official authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 9572B, IAB 6/29/11, effective 8/3/11; ARC 0869C, IAB 7/24/13, effective 8/28/13; ARC 1719C, IAB 11/12/14, effective 12/17/14]

282—22.4(272) Licenses—issue dates, corrections, duplicates, and fraud.

22.4(1) *Issue date on original authorization.* An authorization is valid only from and after the date of issuance.

22.4(2) *Correcting authorization.* If an applicant notifies board staff of a typographical or clerical error on the authorization within 30 days of the date of the board's mailing of an authorization, a corrected authorization shall be issued without charge to the applicant. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of an authorization, a corrected authorization shall be issued upon receipt of the fee for issuance of a duplicate authorization. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of an authorization, or errors in the type of authorization issued.

22.4(3) *Duplicate authorization.* Upon application and payment of the fee set out in 282—Chapter 12, a duplicate authorization shall be issued.

22.4(4) *Fraud in procurement or renewal of authorization.* Fraud in procurement or renewal of an authorization or falsifying records for authorization purposes will constitute grounds for filing a complaint with the board of educational examiners.

[ARC 9572B, IAB 6/29/11, effective 8/3/11]

282—22.5(272) Preliminary native language teaching authorization.

22.5(1) *Authorization.* The preliminary native language teaching authorization is provided to noneducators entering the education profession to teach their native language as a foreign language in grades K-6 or grades 7-12.

22.5(2) *Application process.* Any person interested in the preliminary native language teaching authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at <http://www.boee.iowa.gov/>.

22.5(3) *Requirements.*

- a. The applicant must have completed a baccalaureate degree.
- b. Iowa division of criminal investigation background check. The applicant must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.

c. National criminal history background check. The applicant must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

d. The applicant must obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant. Before the applicant is hired, the school district administrator must verify that a diligent search was completed to hire a fully licensed teacher for the position.

e. During the term of the authorization, the applicant must complete board-approved training in the following:

(1) Methods and techniques of teaching. Develop skills to use a variety of learning strategies that encourage students' development of critical thinking, problem solving, and performance skills. The methods course must include specific methods and techniques of teaching a foreign language and must be appropriate for the level of endorsement.

(2) Curriculum development. Develop an understanding of how students differ in their approaches to learning and create learning opportunities that are equitable and adaptable to diverse learners.

(3) Measurement and evaluation of programs and students. Develop skills to use a variety of authentic assessments to measure student progress.

(4) Classroom management. Develop an understanding of individual and group motivation and behavior which creates a learning environment that encourages positive social interactions, active engagement in learning, and self-motivation.

(5) Code of ethics. Develop an understanding of how to foster relationships with parents, school colleagues, and organizations in the larger community to support students' learning and development and become aware of the board's rules of professional practice and code of ethics.

(6) Diversity training for educators. Develop an understanding of and sensitivity to the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society, including preparation that contributes to the education of individuals with disabilities and the gifted and talented.

f. The applicant must be assigned a mentor by the hiring school district. The mentor must have four years of teaching experience in a related subject area.

g. Assessment of native language. The applicant must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education. The cut score may not be waived by the board.

22.5(4) *Validity.* This authorization is valid for three years. No Class B licenses may be issued to applicants holding the preliminary native language teaching authorization. No additional endorsement areas may be added unless the requirements in 22.5(3) are met.

22.5(5) *Renewal.* The authorization is nonrenewable.

22.5(6) *Conversion.* The preliminary native language teaching authorization may be converted to a native language teaching authorization. The applicant must provide official transcripts verifying the completion of the coursework required in 22.5(3) "e."

22.5(7) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the preliminary native language teaching authorization. If a school district hires an applicant without a valid preliminary native language teaching authorization, a complaint may be filed against the teacher and the superintendent of the school district.

22.5(8) *Approval of courses.* Each institution of higher education, private college or university, community college or area education agency wishing to offer the training for the preliminary native language teaching authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 0562C, IAB 1/23/13, effective 2/27/13]

282—22.6(272) Native language teaching authorization.

22.6(1) *Authorization.* The native language teaching authorization allows an individual to teach the individual's native language as a foreign language in grades K-8 or grades 5-12.

22.6(2) Application process. Any person interested in the native language teaching authorization shall submit an application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at <http://www.boee.iowa.gov/>.

22.6(3) Requirements. Applicants must:

a. Hold a preliminary native language teaching authorization and meet the conversion requirements for the native language teaching authorization, or

b. Hold an Iowa teaching license and provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education. The cut score may not be waived by the board. Applicants who hold an Iowa teaching license must also obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant. Before the applicant is hired, the school district administrator must verify that a diligent search was completed to hire a fully licensed teacher with the proper endorsement for the position.

22.6(4) Validity. This authorization is valid for five years. No Class B licenses may be issued to an applicant holding the native language teaching authorization unless a teaching license is additionally obtained. No additional endorsement areas may be added to the native language teaching authorization.

22.6(5) Renewal.

a. Applicants must meet the renewal requirements set forth in rule 282—20.3(272) and 282—subrule 20.5(2).

b. A one-year extension may be issued if all requirements for the renewal of the native language teaching authorization have not been met. This one-year extension is not renewable.

22.6(6) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the native language teaching authorization. If a school district hires an applicant without the proper licensure or endorsement, a complaint may be filed.

[ARC 1721C, IAB 11/12/14, effective 12/17/14]

282—22.7(272) School administration manager authorization.

22.7(1) Application for authorization. Effective July 1, 2014, a person who is interested in a school administration manager authorization will be required to apply for an authorization. The following persons must obtain an authorization:

a. A Model 1 SAM, a person who is hired to be a full-time SAM and who is authorized to assume the responsibilities of a SAM;

b. A Model 2 SAM, a person whose position in the school is reconfigured to include the responsibilities of being a SAM and is authorized as a SAM; and

c. A Model 3 SAM, a person who is a secretary/administrative assistant and is also authorized as a SAM.

22.7(2) Responsibilities. A school administration manager authorization allows an individual to assist a school administrator in performing noninstructional, administrative-type duties.

22.7(3) Application process. Any person interested in the school administration manager authorization shall submit to the board of educational examiners an application which includes a written verification of employment from a school district administrator. Application materials are available from the office of the board of educational examiners, online at <http://www.boee.iowa.gov/>.

A person serving as a school administration manager prior to July 1, 2014, is eligible for the standard school administration manager authorization, subject to the Iowa division of criminal investigation and national criminal history background checks. The person will be assessed the background check fee. The school administration manager must have completed the school administration manager training and be listed on the Basic Educational Data Survey as a school administration manager by October 31, 2013. The application fee for such persons will be waived if the application is received prior to June 30, 2014.

22.7(4) Specific requirements for an initial school administration manager authorization. Applicants for an initial school administration manager authorization shall have completed the following requirements:

a. *Education.* Applicants must hold a high school degree or general equivalency diploma.

b. *Minimum age.* Applicants must have attained a minimum age of 18 years.

c. *Iowa division of criminal investigation background check.* Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.

d. *National criminal history background check.* Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

22.7(5) Specific requirements for a standard school administration manager authorization. The initial school administration manager authorization shall be converted to the standard school administration manager authorization provided the following requirements are met.

a. *Training.* A school administration manager shall attend an approved training program at the onset of the individual's hire as a school administration manager. The training for school administration managers is set forth in 281—subrule 82.7(2).

b. *Experience.* An applicant shall complete one year of experience as a school administration manager in an Iowa school. The supervising administrator shall verify this experience and the applicant's completion of the required competencies.

c. *Competencies.* Applicants shall demonstrate completion of or competency in the following:

(1) Each school administration manager shall demonstrate competence in technology appropriate to the school administration manager position. The school administration manager will:

1. Become proficient in the use of the approved time-tracking software tool;
2. Schedule the administrator's time using the approved software, update and reconcile the calendar daily, and attempt to pre-calendar the administrator at or above the administrator's goal; and
3. Regularly schedule, review, and reflect with the administrator on the graphs and data provided through the software.

(2) Each school administration manager shall demonstrate appropriate personal skills. The school administration manager:

1. Is an effective communicator with all stakeholders, including but not limited to colleagues, community members, parents, and students;
2. Works effectively with employees, students, and stakeholders.
3. Maintains confidentiality when dealing with student, parent, and staff issues;
4. Clearly understands the administrator's philosophy of behavior expectations and consequences; and
5. Maintains an environment of mutual respect, rapport, and fairness.

22.7(6) Validity.

a. The initial school administration manager authorization shall be valid for three years.

b. The standard school administration manager authorization shall be valid for five years.

22.7(7) Renewal.

a. The initial school administration manager authorization may be renewed once if the applicant has not previously had employment as a school administration manager but can at the time of application provide evidence of employment as a school administration manager.

b. The standard school administration manager authorization may be renewed upon application and verification of successful completion of the following:

(1) *Renewal activities.* The applicant for renewal must complete three semester hours of credit through authorized SAM training or online training courses approved by the board of educational examiners in collaboration with the department of education.

(2) *Child and dependent adult abuse mandatory reporter training.* Every renewal applicant must submit documentation of completion of the child and dependent adult abuse mandatory reporter training approved by the state abuse education review panel. A waiver of this requirement may apply under any of the following appropriately documented conditions:

1. The person is engaged in active duty in the military service of this state or of the United States.

2. The person has previously renewed a license or another authorization issued by the board of educational examiners and, at that time, reported the completion, within the past five years, of child and dependent adult abuse mandatory reporter training approved by the state abuse education review panel.

22.7(8) Extension. A one-year extension of the school administration manager authorization may be issued if the applicant does not meet the renewal requirements. The applicant must secure the signature of the superintendent or designee before the extension will be issued.

22.7(9) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the school administration manager authorization.

22.7(10) Approval of courses. Each institution of higher education, private college or university, community college, area education agency and professional organization that wishes to offer the semester credit hours for the school administration manager authorization must submit course descriptions for each offering to the board of educational examiners for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the board of educational examiners.

[ARC 1086C, IAB 10/16/13, effective 11/20/13; ARC 1542C, IAB 7/23/14, effective 8/27/14; ARC 1721C, IAB 11/12/14, effective 12/17/14]

282—22.8(272) iJAG authorization.

22.8(1) Authorization. The Iowa jobs for America's graduates (iJAG) authorization is provided to noneducators entering the education profession to teach iJAG coursework in grades 7-12.

22.8(2) Application process. Any person interested in the iJAG authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at <http://www.boee.iowa.gov>.

22.8(3) Requirements.

- a. The applicant must have completed a baccalaureate degree.
- b. Iowa division of criminal investigation background check. The applicant must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.
- c. National criminal history background check. The applicant must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.
- d. The applicant must have completed a board of educational examiners-approved iJAG training program consisting of the following components and totaling a minimum of 40 clock hours annually:
 - (1) Instructional methods. Develop skills to effectively deliver project-based instruction in the iJAG core competencies.
 - (2) Curriculum. Develop skills to effectively develop curriculum, projects and other educational opportunities consistent with the goals of iJAG.
 - (3) Measurement and evaluation of programs and students. Analyze student data, administer testing, and monitor the following: basic skills, individualized development plans, attendance, graduation requirements, and course enrollment.
 - (4) Code of ethics. Develop an understanding of how to foster relationships with parents, students, school colleagues, and organizations in the larger community to support students' learning and development and become aware of the board's rules of professional practice and code of ethics.
 - (5) Diversity training for educators. Develop an understanding of and sensitivity to the values, beliefs, lifestyles and attitudes of individuals and the diverse groups found in a pluralistic society, including preparation that contributes to the education of individuals with disabilities and the gifted and talented.

e. The applicant must obtain a recommendation from an iJAG administrator verifying that the organization wishes to hire the applicant.

f. The applicant must be assigned a mentor by the hiring school district. The mentor must have four years of teaching experience.

22.8(4) Validity. This authorization is valid for five years. No Class B license or license based on administrative decision may be issued to an applicant holding the iJAG authorization unless a

teaching license is additionally obtained. No additional endorsement areas may be added to the iJAG authorization.

22.8(5) *Renewal.* An applicant for renewal of the iJAG authorization must provide verification of completion of the following:

- a. Required iJAG training as verified through an iJAG administrator.
- b. Child and dependent adult abuse training as stated in 282—subrule 20.3(4).

22.8(6) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holder of the iJAG authorization.

[ARC 1322C, IAB 2/19/14, effective 3/26/14; ARC 1721C, IAB 11/12/14, effective 12/17/14]

282—22.9(272) Requirements for the career and technical secondary authorization.

22.9(1) *Authorization.* This authorization is provided to noneducators entering the education profession to instruct in occupations and specialty fields that are recognized in career and technical service areas and career cluster areas.

22.9(2) *Application process.* Any person interested in the career and technical secondary authorization shall submit the application to the board of educational examiners for an evaluation. Application materials are available from the office of the board of educational examiners online at <http://www.boee.iowa.gov/>.

22.9(3) *Specific requirements for the initial career and technical secondary authorization.*

a. The applicant must meet the background check requirements for licensure set forth in rule 282—13.1(272).

b. The applicant must obtain a recommendation from a school district administrator verifying that the school district wishes to hire the applicant.

c. An applicant for this authorization must have completed 6,000 hours of recent and relevant career and technical experience in the teaching endorsement area sought. If the candidate also holds a bachelor's degree, the experience requirement is 4,000 hours. This experience shall have been accrued within the ten years prior to the date of application. Experience that does not meet these criteria may be considered at the discretion of the executive director. In subjects for which state registration, certification or licensure is required, the applicant must hold the appropriate license, registration or certificate before the initial career and technical secondary authorization or the career and technical secondary authorization will be issued.

d. The applicant must provide documentation of completion of a code of professional conduct and ethics training approved by the board of educational examiners.

e. Coursework requirements.

(1) Applicants must commit to complete the following requirements within the term of the initial authorization. Coursework must be completed for college credit from a regionally accredited institution.

1. A new teachers' workshop of a minimum of 30 clock hours and specified competencies, to be completed during the term of the initial authorization.

2. Coursework in the methods and techniques of career and technical education.

3. Coursework in course and curriculum development.

4. Coursework in the measurement and evaluation of programs and students.

5. An approved human relations course.

6. Coursework in the instruction of exceptional learners to include the education of individuals with disabilities and the gifted and talented.

(2) Applicants who believe that their previous college coursework meets the coursework requirements in 22.9(3)“e”(1) may have the specific requirements waived. Transcripts or other supporting data should be provided to a teacher educator at one of the institutions which has an approved teacher education program. The results of the competency determination shall be forwarded with recommendations to the board of educational examiners. Board personnel will make final determination as to the competencies mastered and cite coursework which yet needs to be completed, if any.

22.9(4) *Validity—initial authorization.* The initial career and technical secondary authorization is valid for three years.

22.9(5) *Renewal.* The initial career and technical secondary authorization may be renewed once if the candidate can demonstrate that coursework progress has been made.

22.9(6) *Conversion.* The initial career and technical secondary authorization may be converted to a career and technical secondary authorization if the applicant has met the following:

- a. Completion of the required coursework set forth in paragraph 22.9(3) “e.”
- b. Documentation of completion of a code of professional conduct and ethics training approved by the board of educational examiners. The training must be completed after the issuance of the initial authorization and no more than three years prior to the date of application.

22.9(7) *Specific requirements for the career and technical secondary authorization.*

- a. This authorization is valid for five years.
- b. An applicant for this authorization must first meet the requirements for the initial career and technical secondary authorization.

c. Renewal requirements for the career and technical secondary authorization. Applicants for renewal must meet the requirements set forth in 282—subrule 20.5(1) and 282—paragraphs 20.5(2) “a” to “d.”

22.9(8) *Revocation and suspension.* Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the initial career and technical secondary authorization or the career and technical secondary authorization. If a school district hires an applicant without a valid license or authorization, a complaint may be filed against the teacher and the superintendent of the school district.

[ARC 2015C, IAB 6/10/15, effective 7/15/15]

282—22.10(272) Activities administration authorization. An activities administration authorization allows an individual to administer any pupil activity program in a K-12 school setting.

22.10(1) *Application process.* Any person interested in the activities administration authorization shall submit an application and records of credit to the board of educational examiners for an evaluation of the required courses or contact hours. Application materials are available from the office of the board of educational examiners online at <http://www.boee.iowa.gov>.

a. *Requirements.* Applicants for the activities administration authorization shall meet the following requirements:

(1) Degree. A baccalaureate degree or higher in athletic administration or related field from a regionally accredited institution is required.

(2) Credit hours. Applicants must complete credit hours or courses offered by the Leadership Training Institute (LTI) from the National Interscholastic Athletic Administrators Association in the following areas:

1. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of risk management, Title IX, sexual harassment, hazing, Americans with Disabilities Act (ADA), and employment law as they pertain to the role of the activities administrator.

2. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of activities administration foundations including philosophy, leadership, professional programs and activities administration principles, strategies and methods.

3. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of the role of the activities director in supporting and developing sports medicine programs, management of athletic player equipment, concussion assessment and proper fitting of athletic protective equipment, and sports field safety.

4. Successful completion of 1 semester credit hour or LTI course relating to knowledge and understanding of the techniques and theory of coaching concepts and strategies for interscholastic budget and concepts and strategies for interscholastic fundraising.

5. Successful completion of 1 semester credit hour or LTI course, approved by the board, relating to the assessment and evaluation of interscholastic athletic programs and personnel, dealing with challenging personalities, and administration of professional growth programs for interscholastic personnel.

6. Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

b. Minimum age. Applicants must have attained a minimum age of 21 years.

c. Iowa division of criminal investigation background check. Applicants must have successfully completed an Iowa division of criminal investigation background check. The background check fee will be assessed to the applicant.

d. National criminal history background check. Applicants must have successfully completed a national criminal history background check. The background check fee will be assessed to the applicant.

22.10(2) Validity. The activities administration authorization shall be valid for five years.

22.10(3) Renewal.

a. The authorization may be renewed upon application and verification of successful completion of the following renewal activities:

(1) Applicants for renewal of an activities administration authorization must complete one of the following professional development options:

1. Document attendance at one state IHSADA convention and one LTI course relating to the knowledge and understanding of professional ethics and legal responsibilities of activities administrators.

2. Complete three LTI courses.

3. Complete 2 semester hours of college credit from a regionally accredited institution.

4. Complete 2 licensure renewal credits from an approved provider.

(2) Applicants for renewal of an activities authorization must complete child and dependent adult abuse training as stated in 282—subrule 20.3(4).

b. A one-year extension of the applicant's activities administration authorization may be issued if all requirements for the renewal of the activities administrator authorization have not been met. The one-year extension is nonrenewable.

22.10(4) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the activities administration authorization.

[ARC 1718C, IAB 11/12/14, effective 12/17/14]

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 23
BEHIND-THE-WHEEL DRIVING INSTRUCTOR AUTHORIZATION

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 21]

282—23.1(272,321) Requirements. Applicants for the behind-the-wheel driving instructor authorization shall meet the following requirements:

23.1(1) Qualifications. To qualify for the behind-the-wheel driving instructor authorization, the applicant must:

- a. Be at least 25 years of age.
- b. Hold a valid driver's license that permits unaccompanied driving, other than a motorized bicycle license or a temporary restricted license.
- c. Have a clear driving record for the previous two years. A clear driving record means that the individual has:
 - (1) Not been identified as a candidate for driver's license suspension under the habitual violator provisions of rule 761—615.13(321) or serious violation provisions of rule 761—615.17(321).
 - (2) No driver's license suspensions, revocations, denials, cancellations, disqualifications, or bars.
 - (3) Not committed an offense which results in driver's license suspension, revocation, denial, cancellation, disqualification, or bar.
 - (4) No record of an accident for which the individual was convicted of a moving traffic violation.

23.1(2) Approved coursework. The applicant shall successfully complete a behind-the-wheel driving instructor course approved by the department of transportation. At a minimum, classroom instruction shall include at least 12 clock hours of observed behind-the-wheel instruction and 24 clock hours of classroom instruction to include psychology of the young driver, behind-the-wheel teaching techniques, ethical teaching practices, and route selection.

23.1(3) Classroom instruction. To be eligible to provide classroom instruction, holders of the behind-the-wheel driving instructor authorization must additionally hold a valid or expired initial, standard, exchange, or master educator license with endorsement for driver education as set forth in 282—subrule 13.28(4).

[ARC 8608B, IAB 3/10/10, effective 4/14/10; ARC 2018C, IAB 6/10/15, effective 7/15/15]

282—23.2(272,321) Validity. The behind-the-wheel driving instructor authorization shall be valid for one year. The behind-the-wheel driving instructor authorization shall be valid only if the holder continues to be qualified under subrule 23.1(1).

[ARC 8131B, IAB 9/9/09, effective 10/14/09; ARC 0865C, IAB 7/24/13, effective 8/28/13]

282—23.3(272,321) Approval of courses. Each institution of higher education, private college or university, community college or area education agency wishing to offer the behind-the-wheel driving instructor authorization must submit course descriptions to the department of transportation for approval. After initial approval, any changes by agencies or institutions in course offerings shall be filed with the department of transportation and the board of educational examiners.

282—23.4(272,321) Application process. Any person interested in the behind-the-wheel driving instructor authorization shall submit records of completion of a department of transportation-approved program to the board of educational examiners for an evaluation of completion of coursework and all other requirements. Application materials are available from the board of educational examiners or the department of transportation or from institutions or agencies offering department of transportation-approved courses.

282—23.5(272,321) Renewal. All fees are nonrefundable. The behind-the-wheel driving instructor authorization may be renewed upon application and verification of successful completion of:

23.5(1) Providing behind-the-wheel instruction for a minimum of 12 clock hours during the previous school year; and

23.5(2) Successful participation in at least one department of transportation-sponsored or department of transportation-approved behind-the-wheel instructor refresher course; and

23.5(3) Effective September 1, 2002, the child and dependent adult abuse training approved by the state abuse education review panel. A waiver of this requirement may apply under the following conditions with appropriate documentation of any of the following:

- a.* The person is engaged in active duty in the military service of this state or of the United States.
- b.* The application of this requirement would impose an undue hardship on the person for whom the waiver is requested.
- c.* The person is practicing a licensed profession outside this state.
- d.* The person is otherwise subject to circumstances that would preclude the person from satisfying the approved child and dependent adult abuse training in this state.
- e.* The person has previously renewed a license or authorization issued by the board of educational examiners and, at that time, reported the completion, within the past five years, of child and dependent adult abuse training approved by the state abuse education review panel.

282—23.6(272,321) Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall be applicable to the holders of the behind-the-wheel driving instructor authorization.

These rules are intended to implement Iowa Code chapter 272 and section 321.178.

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CHAPTER 27
ISSUANCE OF PROFESSIONAL SERVICE LICENSES

282—27.1(272) Professional service license. A professional service licensee is an individual prepared to provide professional services in Iowa schools but whose preparation has not required completion of the teacher preparation coursework set forth in rule 281—79.15(256). The professional service license may be issued in the following areas:

1. School counselor.
2. School psychologist.
3. Speech-language pathologist.
4. Supervisor of special education (support).
5. Director of special education of an area education agency.
6. School social worker.
7. School audiologist.

[ARC 7980B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—27.2(272) Requirements for a professional service license.

27.2(1) Initial professional service license. An initial professional service license valid for two years may be issued to an applicant for licensure to serve as a school audiologist, school psychologist, school social worker, speech-language pathologist, supervisor of special education (support), director of special education of an area education agency, or school counselor who:

- a. Has a master's degree in a recognized professional educational service area from a regionally accredited institution.
- b. Has completed a state-approved program which meets the requirements for an endorsement in a professional educational service area.
- c. Has completed the requirements for one of the professional educational service area endorsements.
- d. Meets the recency requirement of 282—subparagraph 13.5(2)“b”(4).

27.2(2) Standard professional service license. A standard professional service license valid for five years may be issued to an applicant who:

- a. Completes requirements listed under 27.2(1)“a” to “d.”
- b. Shows evidence of successful completion of a state-approved mentoring and induction program by meeting the Iowa standards as determined by a comprehensive evaluation and two years' successful service experience in an Iowa public school. In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful service area experience in an Iowa nonpublic school or three years' successful service area experience in an out-of-state K-12 educational setting.
- c. Meets the recency requirement of 282—subparagraph 13.5(2)“b”(4).

27.2(3) Renewal. Renewal requirements for this license are set out in 282—Chapter 20.

[ARC 7980B, IAB 7/29/09, effective 9/2/09; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—27.3(272) Specific requirements for professional service license endorsements.

27.3(1) Elementary professional school counselor.

a. *Authorization.* The holder of this endorsement has not completed the teacher preparation coursework set forth in rule 281—79.15(256) but is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

b. *Program requirements.*

- (1) Master's degree from an accredited institution of higher education.
- (2) Completion of an approved human relations component.
- (3) Completion of an approved exceptional learner component.

c. *Content.* Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

- (1) The competencies listed in 282—subparagraphs 13.28(26)“c”(1) to (11).

(2) The teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with elementary and middle school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group counseling, developmental classroom guidance, and consultation.

27.3(2) Secondary professional school counselor.

a. Authorization. The holder of this endorsement has not completed the teacher preparation coursework set forth in rule 281—79.15(256) but is authorized to serve as a professional school counselor in grades five through twelve.

b. Program requirements.

- (1) Master's degree from an accredited institution of higher education.
- (2) Completion of an approved human relations component.
- (3) Completion of an approved exceptional learner component.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in 282—subparagraphs 13.28(26) “c”(1) to (11).

(2) The teaching and counseling practicum. The school counselor demonstrates competency in conducting classroom sessions with middle and secondary school students. The practicum consisting of a minimum of 500 contact hours provides opportunities for the prospective counselor, under the supervision of a licensed professional school counselor, to engage in a variety of activities in which a regularly employed school counselor would be expected to participate including, but not limited to, individual counseling, group work, developmental classroom guidance, and consultation.

27.3(3) School psychologist.

a. Authorization. The holder of this endorsement is authorized to serve as a school psychologist with pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant shall have completed a program of graduate study that is currently approved (or that was approved at the time of graduation) by the National Association of School Psychologists or the American Psychological Association, or be certified as a Nationally Certified School Psychologist by the National Association of School Psychologists, in preparation for service as a school psychologist through one of the following options:

1. Completion of a master's degree with sufficient graduate semester hours beyond a baccalaureate degree to total 60; or

2. Completion of a specialist's degree of at least 60 graduate semester hours with or without completion of a terminal master's degree program; or

3. Completion of a doctoral degree program of at least 60 graduate semester hours with or without completion of a terminal master's degree program or specialist's degree program.

(2) The program shall include an approved human relations component.

(3) The program must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

c. School psychologist one-year Class A license.

(1) Requirements for a one-year Class A license. A nonrenewable Class A license valid for one year may be issued to an individual who must complete an internship or thesis as an aspect of an approved program in preparation for the school psychologist endorsement. The one-year Class A license may be issued under the following limited conditions:

1. Verification from the institution that the internship or thesis is a requirement for successful completion of the program.

2. Verification that the employment situation will be satisfactory for the internship experience.

3. Verification from the institution of the length of the approved and planned internship or the anticipated completion date of the thesis.

4. Verification of the evaluation processes for successful completion of the internship or thesis.
5. Verification that the internship or thesis is the only requirement remaining for successful completion of the approved program.

(2) Written documentation of the above requirements must be provided by the official at the institution where the individual is completing the approved school psychologist program and forwarded to the board of educational examiners with the application form for licensure.

27.3(4) *Speech-language pathologist.* A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. The holder of this endorsement is authorized to serve as a speech-language pathologist to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

- (1) An applicant must hold a master's degree in speech pathology.
- (2) Content. An applicant must have completed the requirements in speech pathology and in the professional education sequence, i.e., 20 semester hours including student teaching/internship as a school speech-language pathologist. Courses in the following areas may be recognized for fulfilling the 20-hour sequence:

1. Curriculum courses (e.g., reading, methods, curriculum development).
2. Foundations (e.g., philosophy of education, foundations of education).
3. Educational measurements (e.g., school finance, tests and measurements, measures and evaluation of instruction).
4. Educational psychology (e.g., educational psychology, educational psychology measures, principles of behavior modification).
5. Courses in special education (e.g., introduction to special education, learning disabilities).
6. Child development courses (e.g., human growth and development, principles and theories of child development, history and theories of early childhood education).

NOTE: General education courses (e.g., introduction to psychology, sociology, history, literature, humanities) will not be credited toward fulfillment of the required 20 hours.

- (3) The applicant must complete an approved human relations component.
- (4) The program must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

27.3(5) *Professional service administrator.*

a. Authorization. The holder of this endorsement is authorized to serve as a supervisor of special education support programs. However, an individual holding a statement of professional recognition is not eligible for the professional service administrator endorsement.

b. Program requirements.

- (1) An applicant must hold a master's degree in preparation for school psychology, speech/language pathology, audiology (or education of the hearing impaired), or social work.
- (2) Content. The program shall include a minimum of 16 graduate semester hours to specifically include the following:

1. Consultation process in special or regular education.
2. Current issues in special education administration including school law/special education law.
3. Program evaluation.
4. Educational leadership.
5. Administration and supervision of special education.
6. Practicum: Special education administration. NOTE: This requirement may be waived based on two years of experience as a special education administrator.

7. School personnel administration.

8. Evaluator approval component.

c. Other. The applicant must:

(1) Have four years of support service in a school setting with special education students in the specific discipline area desired.

(2) Meet the practitioner licensure requirements of one of the following endorsements:

1. School audiologist (or hearing impaired at K-8 and 5-12).
2. School psychologist.
3. School social worker.
4. Speech-language pathologist.

27.3(6) Director of special education of an area education agency.

a. Authorization. The holder of this endorsement is authorized to serve as a director of special education of an area education agency. Assistant directors are also required to hold this endorsement. However, an individual holding a statement of professional recognition is not eligible for the director of special education of an area education agency endorsement.

b. Program requirements.

(1) Degree—specialist or its equivalent. An applicant must hold a master's degree plus at least 32 semester hours of planned graduate study in administration or special education beyond the master's degree.

(2) Endorsement. An applicant must hold or meet the requirements for one of the following:

1. PK-12 principal and PK-12 supervisor of special education (see rule 282—18.9(272));
2. Supervisor of special education—instructional (see rule 282—15.5(272));
3. Professional service administrator (see subrule 27.3(5)); or
4. A letter of authorization for special education supervisor issued prior to October 1, 1988.

(3) Content. An applicant must have completed a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements to include the following:

1. Knowledge of federal, state and local fiscal policies related to education.
2. Knowledge of school plant/facility planning.
3. Knowledge of human resources management, including recruitment, personnel assistance and development, evaluations, and negotiations.
4. Knowledge of models, theories and philosophies that provide the basis for educational systems.
5. Knowledge of current issues in special education.
6. Knowledge of special education school law and legislative and public policy issues affecting children and families.
7. Knowledge of the powers and duties of the director of special education of an area education agency as delineated in Iowa Code section 273.5.
8. Practicum in administration and supervision of special education programs.

(4) Experience. An applicant must have three years of administrative experience as a PK-12 principal or PK-12 supervisor of special education.

(5) Competencies. Through completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements, the director of special education accomplishes the following:

1. Facilitates the development, articulation, implementation and stewardship of a vision of learning that is shared and supported by the school community.
2. Advocates, nurtures and sustains a school culture and instructional program conducive to student learning and staff professional growth.
3. Ensures management of the organization, operations and resources for a safe, efficient and effective learning environment.
4. Collaborates with educational staff, families and community members; responds to diverse community interests and needs; and mobilizes community resources.
5. Acts with integrity and fairness and in an ethical manner.
6. Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.
7. Collaborates and assists in supporting integrated work of the entire agency.

c. Other.

(1) Option 1: Instructional. An applicant must meet the requirements for one special education teaching endorsement and have three years of teaching experience in special education.

(2) Option 2: Support. An applicant must meet the practitioner licensure requirements for one of the following endorsements and have three years of experience as a:

1. School audiologist;
2. School psychologist;
3. School social worker; or
4. Speech-language pathologist.

27.3(7) School social worker. A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. An individual who meets the requirements of 282—paragraph 15.7(5) “b” or 282—subrule 16.6(2) is authorized to serve as a school social worker to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Endorsement requirements. An applicant must hold a master’s degree in social work from an accredited school of social work to include a minimum of 20 semester hours of coursework (including practicum experience) which demonstrates skills, knowledge, and competencies in the following areas:

- (1) Social work.
 1. Assessment (e.g., social, emotional, behavioral, and familial).
 2. Intervention (e.g., individual, group, and family counseling).
 3. Related studies (e.g., community resource coordination, multidiscipline teaming, organizational behavior, and research).
- (2) Education.
 1. General education (e.g., school law, foundations of education, methods, psychoeducational measurement, behavior management, child development).
 2. Special education (e.g., exceptional children, psychoeducational measurement, behavior management, special education regulations, counseling school-age children).
- (3) Practicum experience. A practicum experience in a school setting under the supervision of an experienced school social work practitioner is required. The practicum shall include experiences that lead to the development of professional identity and the disciplined use of self. These experiences will include: assessment, direct services to children and families, consultation, staffing, community liaison and documentation. If a person has served two years as a school social worker, the practicum experience can be waived.
- (4) Completion of an approved human relations component is required.
- (5) The program must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

27.3(8) School audiologist. A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. The holder of this endorsement is authorized to serve as a school audiologist to pupils from birth to age 21 who have hearing impairments (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

- (1) An applicant must hold a master’s degree in audiology.
- (2) Content. An applicant must complete the requirements in audiology and in the professional education sequence, i.e., 20 semester hours including student teaching/internship as a school audiologist. Courses in the following areas may be recognized for fulfilling the 20-hour sequence:
 1. Curriculum courses (e.g., reading, methods, curriculum development).
 2. Foundations (e.g., philosophy of education, foundations of education).

3. Educational measurements (e.g., school finance, tests and measurements, measures and evaluation of instruction).
4. Educational psychology (e.g., educational psychology, educational psychology measures, principles of behavior modification).
5. Courses in special education (e.g., introduction to special education, learning disabilities).
6. Child development courses (e.g., human growth and development, principles and theories of child development, history of early childhood education).

NOTE: General education courses (e.g., introduction to psychology, sociology, history, literature, humanities) will not be credited toward fulfillment of the required 20 hours.

(3) An applicant must complete an approved human relations component.

(4) The program must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

[ARC 7980B, IAB 7/29/09, effective 9/2/09; ARC 9074B, IAB 9/8/10, effective 10/13/10; ARC 9076B, IAB 9/8/10, effective 10/13/10; ARC 1328C, IAB 2/19/14, effective 3/26/14; ARC 2016C, IAB 6/10/15, effective 7/15/15]

282—27.4(272) Specific renewal requirements for the initial professional service license.

27.4(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

27.4(2) If a person meets all requirements for the standard professional service license except for the requirements in paragraph 27.2(2) “b,” the initial professional service license may be renewed upon written request. A second renewal may be granted if the holder of the initial license has not met the requirements in paragraph 27.2(2) “b” and if the license holder can provide evidence of employment which will be acceptable for the experience requirement.

[ARC 8609B, IAB 3/10/10, effective 4/14/10]

282—27.5(272) Specific renewal requirements for the standard professional service license.

27.5(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth in rule 282—20.3(272).

27.5(2) Four units are needed for renewal. These units may be earned in any combination listed below:

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned master’s, specialist’s, or doctor’s degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved pursuant to guidelines established by the board of educational examiners.

[ARC 8609B, IAB 3/10/10, effective 4/14/10]

282—27.6(272) Specific requirements for a Class B license. A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

27.6(1) *Endorsement in progress.* The individual has a valid professional service license and one or more professional service endorsements, but is seeking to obtain some other professional service endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other professional service endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement.

27.6(2) *Request for exception.* A school district administrator may file a written request with the board for an exception to the minimum content requirements on the basis of documented need and benefit

to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

27.6(3) Expiration. This license will expire on June 30 of the fiscal year in which it was issued plus one year.

[ARC 8959B, IAB 7/28/10, effective 9/1/10]

282—27.7(272) Timely renewal. A license may only be renewed less than one year before it expires.

[ARC 9452B, IAB 4/6/11, effective 5/11/11]

These rules are intended to implement Iowa Code chapter 272.

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CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.

75.1(1) *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

- a. Persons denied RCA because the amount of payment would be less than \$10.
- b. Rescinded IAB 7/30/08, effective 10/1/08.
- c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) *Persons receiving care in a medical facility who would be eligible under a special income standard.*

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
 - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
 - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A “period of 30 days” is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain “under the jurisdiction of the institution” a person must first have been physically admitted to the institution.

75.1(8) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of “essential person” in effect in the public assistance program on December 31, 1973.

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

75.1(10) *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

- (1) Failure to provide information, or
- (2) Failure to comply with other procedural requirements.

75.1(12) *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

- a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and
- b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and
- c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

75.1(14) *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

- a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed \$2,000 for applicant households or \$5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.
- b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).
- c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2) "a," "b," "c," and "d" shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1) "a" but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8) "c" and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the \$30 or the \$30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins

with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) "b" and "c," shall be treated in accordance with paragraphs 75.57(9) "b" and "c."

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed \$10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, “family” shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. “Family” also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months’ Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph “*f*” below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs “*g*” and “*i*” of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)“*f*” and 75.57(2)“*l*.”

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional

six-month period as required in paragraph 75.1(31)“h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family’s control.
4. There was a failure to receive the department’s notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client’s achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family’s average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1)“a,” including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph “g” or “i” above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person’s monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person’s resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person’s income and resources shall be determined as under the SSI program.

75.1(34) Specified low-income Medicare beneficiaries. Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) Medically needy persons.

a. Coverage groups. Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. Resources and income of all persons considered.

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. Resources.

(1) The resource limit for adults in SSI-related households shall be \$10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) “b,” “c,” “g,” “h,” and “i” regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	\$483	\$483	\$566	\$666	\$733	\$816	\$891	\$975	\$1058	\$1158

Each additional person \$116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the

provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs “1” through “3” above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.
- (3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) Expanded specified low-income Medicare beneficiaries. As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

- a. The person is not otherwise eligible for Medicaid.
- b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.
- d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.
- e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) Home health specified low-income Medicare beneficiaries. Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) Continued Medicaid for disabled children from August 22, 1996. Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) Working persons with disabilities.

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
 - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
 - (2) They are less than 65 years of age.
 - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.
 - (4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)“c.”
 - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)“a”(1) above.
 - (6) They have paid any premium assessed under paragraph 75.1(39)“b” below.
- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social

security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$32
165% of Federal Poverty Level	\$44
180% of Federal Poverty Level	\$53
200% of Federal Poverty Level	\$62
225% of Federal Poverty Level	\$73
250% of Federal Poverty Level	\$84
300% of Federal Poverty Level	\$106
350% of Federal Poverty Level	\$130
400% of Federal Poverty Level	\$153
450% of Federal Poverty Level	\$177
550% of Federal Poverty Level	\$221
650% of Federal Poverty Level	\$268
750% of Federal Poverty Level	\$316
850% of Federal Poverty Level	\$375
1000% of Federal Poverty Level	\$451
1150% of Federal Poverty Level	\$530
1300% of Federal Poverty Level	\$612
1480% of Federal Poverty Level	\$707

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to Form 470-3902, MEPD Billing Statement.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPD Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It

includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

“Family,” if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, *“family”* includes the individual’s spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual’s family. An individual living alone or with others not listed above shall be considered to be a family of one.

“Medical savings account” means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

“Retirement account” means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) *“f”* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer:*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph *“a”* continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph *“a”* shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer

screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Persons eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available as provided in this subrule.

a. Eligibility. The following are eligible for assistance under this coverage group if they are not otherwise enrolled in Medicaid (other than IowaCare):

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who have reached childbearing age, are under 55 years of age, are capable of bearing children but are not pregnant, and have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

(3) Men who are under 55 years of age, who are capable of fathering children, and who have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

b. Application.

(1) Women eligible under subparagraph 75.1(41)“a”(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) A person requesting assistance based on subparagraph 75.1(41)“a”(2) or 75.1(41)“a”(3) shall file an application as required in rule 441—76.1(249A).

c. Determining income eligibility. The department shall determine the countable income of an applicant applying under subparagraph 75.1(41)“a”(2) or 75.1(41)“a”(3) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in paragraph 75.54(1)“b.”

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.

2. Child support.

3. Alimony.

4. Social security and railroad retirement benefits.

5. Worker’s compensation and disability payments.

6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in subrule 75.57(2).

(5) Disregard of changes. A person found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

d. Effective date. Assistance for family planning services under this coverage group shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

75.1(42) Medicaid for independent young adults. Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

a. The person is at least 18 years of age and under 21 years of age.

b. On the person’s eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.

c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

(1) "Household" shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person's own children;
2. The person's spouse; and
3. Any children of the person's spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person's household. A person who lives alone or with others not listed above, including the person's parents, shall be considered a household of one.

(2) The department shall determine the household's countable income pursuant to rule 441—75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) Medicaid for children with disabilities. Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) Presumptive eligibility for children. Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. *Qualified entity.* A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

- (1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and
- (2) Has signed an agreement with the department as a qualified entity.

b. Application process. Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) “f.” The qualified entity shall use the department’s Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child’s presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. Eligibility requirements. To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household’s gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. Period of presumptive eligibility. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child’s eligibility during the presumptive period.

e. Services covered. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

75.1(45) Medicaid for former foster care youth. Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;

b. The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but has income that exceeds the level of income applicable under Iowa’s state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

c. The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7833B, IAB 6/3/09, effective 8/1/09; ARC 7929B, IAB 7/1/09, effective 7/1/09; ARC 7931B, IAB 7/1/09, effective 7/1/09; ARC 8095B, IAB 9/9/09, effective 10/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8261B, IAB 11/4/09, effective 10/15/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8713B, IAB 5/5/10, effective 8/1/10; ARC 8897B, IAB 6/30/10, effective 9/1/10; ARC 9581B, IAB 6/29/11, effective 8/3/11; ARC 9647B, IAB 8/10/11, effective 8/1/11; ARC 9956B, IAB 1/11/12, effective 1/1/12; ARC 0149C, IAB 6/13/12, effective 8/1/12; ARC 0579C, IAB 2/6/13, effective 4/1/13; ARC 0820C, IAB 7/10/13, effective 8/1/13; ARC 0990C, IAB 9/4/13, effective 1/1/14; ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1482C, IAB 6/11/14, effective 8/1/14; ARC 2029C, IAB 6/10/15, effective 8/1/15]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

- (1) File a claim or submit an application for any reasonably available medical resource, and
- (2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

- a. Physical or emotional harm to the member for whom medical resources are being sought.
- b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in

the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.
[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) When the medical assistance program pays for a member's medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien

under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or

legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

[ARC 9696B, IAB 9/7/11, effective 9/1/11; ARC 9881B, IAB 11/30/11, effective 1/4/12]

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)“a” live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is \$1500 or less per spouse.

(10) An amount, not in excess of \$1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of \$1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

- (1) That the attribution is incorrect, or
- (2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) "d" shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) "f"(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during

the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

b. Definition. “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number.

75.7(1) As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

75.7(2) The requirement of subrule 75.7(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection.

For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(3) If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) Definitions.

a. Institutions. For purposes of this rule, “institution” means an “institution” or a “medical institution” as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, “institution” also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. Incapable of expressing intent regarding residency. For purposes of this rule, an individual is considered to be “incapable of indicating intent regarding residency” if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;
2. Has been judged legally incompetent; or
3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

75.10(2) Determination of residency. State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency:

a. Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

b. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to

that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

c. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

d. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

e. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

- (1) Intends to reside, with or without a fixed address; or
- (2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2) "j."

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2) "k" or "l," the state of residence is:

- (1) The state where the individual resides, with or without a fixed address; or
- (2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2) "j," with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) Definitions.

"Care and services necessary for the treatment of an emergency medical condition" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.

5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.

6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;

- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and

- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"Qualified alien" means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);

2. Who is granted asylum in the United States under Section 208 of the INA;

3. Who is a refugee admitted to the United States under Section 207 of the INA;

4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;

5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;

6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;

7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);

8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);

9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);

10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;

11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or

12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

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

75.11(2) Citizenship and alienage.

a. To be eligible for Medicaid, a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

- (3) A qualified alien under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
- (5) An alien who has been granted asylum under Section 208 of the INA.
- (6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
- (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.
- (10) A qualified alien who has resided in the United States for a period of at least five years.
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
- (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

c. Except as provided in paragraph "*f*," applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph "*b*" shall present satisfactory documentation of citizenship or nationality as defined in paragraph "*d*," "*e*," or "*i*." A reference to a form in paragraph "*d*" or "*e*" includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)"*i*"(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual

who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph “*d*,” “*e*,” or “*i*.” The retroactive months are outside the “reasonable period” during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver’s license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph “*b*” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2)"e"(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)"e"(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph "d" or "e," satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph "d" or "e."

75.11(3) Deeming of sponsor's income and resources.

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8)"b" and a \$1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

b. An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

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

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

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

d. Deeming of the sponsor's income and resources does not apply when:

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

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

75.11(4) Eligibility for payment of emergency medical services. Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

75.12(1) Suspension. Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person's entry into the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person entered the institution;

or

(2) Other verified notice received by the department.

b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

c. On the date of entry into the public institution, the person was a Medicaid member.

d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) Coverage during suspension. While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

75.12(3) Reinstatement. The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

a. The department is notified of the person's release from the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person was released from the institution; or

(2) Other verified notice received by the department.

b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[ARC 9957B, IAB 1/11/12, effective 1/1/12]

441—75.13(249A) Categorical relatedness.

75.13(1) FMAP-related Medicaid eligibility. Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) SSI-related Medicaid. Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3)“b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.
- (4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

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

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

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

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule

75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

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

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

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

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

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

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

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

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

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

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

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

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

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

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

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

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

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

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

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

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

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

(2) Corroborate the good cause circumstances.

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

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

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

(3) Be entered in the case record.

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

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

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

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

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

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

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

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

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

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

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

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

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

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

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

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

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

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

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

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

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

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

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

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

- (1) Advise the applicant or member how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

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

- (1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.
- (2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.
- (3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

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

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

- (1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.
- (2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

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

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

- a.* The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) Income considered in determining client participation. The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

- (1) The client has a parent or child at home.
- (2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

- (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
- (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) Allowable deductions from income. In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. *Ongoing personal needs allowance.* All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. *Personal needs in the month of entry.*

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) Exceptions to coverage. This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children who are eligible only in a retroactive month.

e. Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)"c."

75.19(2) Duration of coverage. Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) Assignment of review date. Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) Disability redeterminations for members who attain age 18. If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

- a. Using the standards applicable to persons who are 18 years of age or older, and
- b. Regardless of whether a review of the member's disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) Individual health plans. Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

- a. A household member is currently enrolled in the plan; and
- b. The health plan is cost-effective as defined in subrule 75.21(2).

75.21(2) Cost-effectiveness. Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

- a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

- b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

- c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

- d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

- (1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

- (2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

- e. Annual administrative expenditures of \$50 per Medicaid member covered under the health plan.

- f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least \$5 per month per household.

75.21(3) Coverage of non-Medicaid-eligible family members.

- a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

- (1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(4) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.
b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.
d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34). Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

k. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

l. The health plan pays secondary to another plan.

m. The only Medicaid members covered by the health plan are currently in foster care.

n. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(5) *Duplicate policies.* When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(6) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be

cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(7) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

e. Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

75.21(9) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(10) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

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

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment.

d. Redeterminations shall be completed whenever:

- (1) A premium rate, deductible, or coinsurance changes,
- (2) A person covered under the policy loses full Medicaid eligibility,
- (3) Changes in employment or hours of employment affect the availability of health insurance,
- (4) The insurance carrier changes,
- (5) The policyholder leaves the Medicaid home, or
- (6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)“a,” shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(11) Time frames for determining cost-effectiveness. The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) Notices.

a. An adequate notice shall be provided to the household under the following circumstances:

- (1) To inform the household of the initial decision on cost-effectiveness and premium payment.
- (2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.
- (3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

- (1) The department has determined the health plan is no longer cost-effective, or
- (2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(13) Rate refund. The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) Reinstatement of eligibility.

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(15) Amount of premium paid.

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(2) and 75.21(3).

75.21(16) Reporting changes. Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 1447C, IAB 4/30/14, effective 7/1/14]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in

the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

- (1) Unobligated cash.
- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage

for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

- a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).
- b. The insurance coverage is no longer available.
- c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.
- d. Funding appropriated for the program is exhausted.
- e. The person with AIDS or an HIV-related illness dies.
- f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

- (1) To inform the applicant of the initial decision regarding eligibility to participate in the program.
- (2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).
- (3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.
- (4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.
- (5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) Ineligibility for services. When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) Look-back date.

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2015, through June 30, 2016, this average statewide cost shall be \$5,407.24 per month or \$177.87 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

- a. The assets transferred were a home and title to the home was transferred to either:
 - (1) A spouse of the individual.
 - (2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.
 - (3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.
 - (4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.
- b. The assets were transferred:
 - (1) To the individual's spouse or to another for the sole benefit of the individual's spouse.
 - (2) From the individual's spouse to another for the sole benefit of the individual's spouse.
 - (3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.
 - (4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.
- c. A satisfactory showing is made that one of the following is true:
 - (1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.
 - (2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.
 - (3) All assets transferred for less than fair market value have been returned to the individual.
- d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:
 - (1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.
 - (2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.
 - (3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:
 1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
 2. Household goods.
 3. A vehicle required by the client for transportation.
 4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless

the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
 2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) "b"(2));
 3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
 4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) "c");
 5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) "d");
- or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9) "b" and also meets the condition described in paragraph 75.23(9) "c."

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) Purchase of promissory notes, loans, or mortgages.

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9) "a" were met.

75.23(11) Purchase of life estates.

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

- (1) The life estate was purchased before February 8, 2006; or
- (2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 3/9/11, effective 5/1/11; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) Establishment of trust.

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

- (1) The purposes for which a trust is established.
- (2) Whether the trustees have or exercise any discretion under the trust.
- (3) Any restrictions on when or whether distribution may be made for the trust.
- (4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) Treatment of revocable and irrevocable trusts.

a. In the case of a revocable trust:

- (1) The principal of the trust shall be considered an available resource.
- (2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
- (3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be

assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) Exceptions. This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2015, to June 30, 2016, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$4,952 per month.
- (2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is \$27,388 per month.
- (3) The average statewide charge to a resident of a mental health institute is \$24,083 per month.
- (4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$6,556 per month.
- (5) The average statewide charge to a home- and community-based waiver applicant or member shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

- (1) The trust is established and managed by a nonprofit association.
- (2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.
- (4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0822C, IAB 7/10/13, effective 7/1/13; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 1483C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“*Aged*” shall mean a person 65 years of age or older.

“*Applicant*” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Blind*” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“*Break in assistance*” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“*Central office*” shall mean the state administrative office of the department of human services.

“*Certification period*” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“*Client*” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*CMAP-related medically needy*” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“*Community spouse*” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Conditionally eligible*” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“*Coverage group*” shall mean a group of persons who meet certain common eligibility requirements.

“*Department*” shall mean the Iowa department of human services.

“*Disabled*” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“*FMAP-related medically needy*” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“*Health insurance*” shall mean protection which provides payment of benefits for covered sickness or injury.

“*Incurred medical expenses*” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“*Institutionalized person*” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“*Institutionalized spouse*” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Local office*” shall mean the county office of the department of human services or the mental health institute or hospital school.

“*Medically needy income level (MNIL)*” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“*Member*” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“*Necessary medical and remedial services*” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

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

“*Nursing facility services*” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“*Obligated medical expense*” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“*Ongoing eligibility*” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“*Pay and chase*” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“*Payee*” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“*Recertification*” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“*Recipient*” shall mean a person who is receiving assistance including receiving assistance for another person.

“*Responsible relative*” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“*Retroactive certification period*” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“*Retroactive period*” shall mean the three calendar months immediately preceding the month in which an application is filed.

“*Spenddown*” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“*SSI-related*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“*SSI-related medically needy*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“*Supply*” shall mean the requested information is received by the department by the specified due date.

“*Transfer of assets*” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

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

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 7935B, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days

after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28(249A) Recovery.

75.28(1) Definitions.

“*Administrative overpayment*” means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

“*Agency error*” means medical assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

“*Client*” means a current or former Medicaid member.

“*Client error*” means medical assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. “*Client error*” also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report as defined in rule 441—76.15(249A).

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

“*Premiums paid for medical assistance*” means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

75.28(2) Amount subject to recovery. The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) Notification. All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures shall include:

- (1) For whom assistance was paid;
- (2) The period during which assistance was incorrectly paid;
- (3) The amount of assistance subject to recovery; and
- (4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums shall include:

- (1) The amount of the premium; and
- (2) The month covered by the medical assistance premium.

75.28(4) Source of recovery. Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

75.28(5) Repayment. The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for persons with an intellectual disability, or mental health institute enrolled as an inpatient psychiatric

facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

75.28(6) Appeals. The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

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

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

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994, when the member:

1. Is under the age of 55; and
2. Is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute; and
3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member's behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of the debt.

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

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

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

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

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph 75.28(7) "g," to the extent that the person received the member's estate, the amount waived shall be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for medical assistance under subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid on behalf of the member before these conditions shall be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child's reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department shall reimburse the county on a proportionate basis.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.29(249A) Investigation by quality control or the department of inspections and appeals. An applicant or member shall cooperate with the department when the applicant's or member's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.30(249A) Member lock-in. In order to promote high-quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, members that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 75.30(7) may be restricted (locked-in) to receive services from a designated provider(s).

75.30(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

75.30(2) Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary provider(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 75.30(3).

75.30(3) Payment will be made to a provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 75.30(5).

c. The designated provider refers the member to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 75.30(5).

75.30(4) When the member fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the member.

75.30(5) Members may change a designated provider(s) when a change is warranted, such as when the member has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the member shall make the determination when the member has demonstrated that a

change is warranted. Members may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

75.30(6) When lock-in is imposed on a member, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

75.30(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception-reporting technique to identify the members most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph 75.30(7) “*a*,” referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid member outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid members who are enrolled in the MediPASS program or a health maintenance organization or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term “physician” does not include a psychiatrist.

c. An investigation process of Medicaid members determined in paragraph 75.30(7) “*a*” or “*b*” to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or as consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

[ARC 1266C, IAB 1/8/14, effective 1/1/14; ARC 1355C, IAB 3/5/14, effective 4/9/14]

441—75.31 to 75.49 Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“*Applicant*” shall mean a person who is requesting assistance on the person’s own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Application period*” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“*Assistance unit*” includes any person whose income is considered when determining eligibility.

“*Bona fide offer*” means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

“*Central office*” shall mean the state administrative office of the department of human services.

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

“*Change in work expenses*” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“*Department*” shall mean the Iowa department of human services.

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

“*Dependent child*” or “*dependent children*” means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

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

“*Initial two months*” means the first two consecutive months for which eligibility is granted.

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

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

“*Needy specified relative*” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“*Nonrecurring lump sum unearned income*” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

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

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

“*Recipient*” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“*Schedule of needs*” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

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

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

“*Uniformed service*” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) Additional reviews. A redetermination of specific eligibility factors shall be made when:

- a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or
- b. A change in the member’s circumstances comes to the attention of a staff member.

75.52(3) Forms.

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

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

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

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

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) Client responsibilities. For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) "f" and 75.57(2) "l."

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) A stepparent recovering from an incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

(8) Receipt of a social security number.

(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8) "b."

(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.

(2) Change of mailing or living address.

(3) Sources of income.

(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.

(2) The mailing or living address changes.

(3) A source of income changes.

- (4) A health insurance premium or coverage change is effective.
- (5) Of any change in income.
- (6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4) “c” through “e,” any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4) “c” through “e.”

75.52(5) Effective date. After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

[ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) Definition of resident. A resident of Iowa is one:

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

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

75.53(2) Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) Absence from the home.

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “b.”

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

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

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

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

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

(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1) "b" as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, "education or training" means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4) "b"(1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

[ARC 0579C, IAB 2/6/13, effective 4/1/13]

441—75.54(249A) Eligibility factors specific to child.

75.54(1) Age. Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) Residing with a relative. The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

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

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

75.54(3) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) Continuous eligibility for children. Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) Specified relationship.

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

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

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

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

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

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

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

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1)“e.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. **EXCEPTION:** Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)“c” reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

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

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

j. Settlements for payment of medical expenses.

k. Life estates.

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

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

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

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group’s property is within the reserve defined in paragraph “e.”

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

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

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

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

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

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate,

more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) Liquidation. When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

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

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

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) Net market value defined. Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) Availability.

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

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

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

b. Rescinded IAB 6/30/99, effective 9/1/99.

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

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

75.56(7) Damage judgments and insurance settlements.

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

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

75.56(8) Conservatorships.

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses

not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1) “*e*” and 75.24(2) “*b*.”

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1) “*e*,” 75.57(6) “*u*,” and 75.57(7) “*o*.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

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

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt

as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“b” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“c” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual’s employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)“a” and “b” and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

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

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)“a”(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

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

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

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

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

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

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

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

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

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

(6) The cost of any repairs needed.

(7) The cost of any travel required.

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

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

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

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

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) Shared living arrangements. When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet

needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

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

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

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

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

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

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

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

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

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

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

b. The value of the food assistance program benefit.

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

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

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

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

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

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

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

- j.* Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.
- k.* Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
- l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- m.* The income of a supplemental security income recipient.
- n.* Income of an ineligible child.
- o.* Income in-kind.
- p.* Family support subsidy program payments.
- q.* Grants obtained and used under conditions that preclude their use for current living costs.
- r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
- s.* Subsidized guardianship program payments.
- t.* Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
- u.* The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
- v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
- (1) The loan is obtained from an institution or person engaged in the business of making loans.
 - (2) There is a written agreement to repay the money within a specified time.
 - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
- w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
- x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
- y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
- z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."
- aa.* Payments received from the Radiation Exposure Compensation Act.
- ab.* Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) Exempt as income. The following are exempt as income.

- a. Reimbursements from a third party.
- b. Reimbursement from the employer for a job-related expense.
- c. The following nonrecurring lump sum payments:
 - (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.
 - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d. Payments received by the family for providing foster care when the family is operating a licensed foster home.
- e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- f. Federal or state earned income tax credit.
- g. Supplementation from county funds, providing:
 - (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
 - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- i. A retroactive corrective family investment program (FIP) payment.
- j. The training allowance issued by the division of vocational rehabilitation, department of education.
- k. Payments from the PROMISE JOBS program.
- l. The training allowance issued by the department for the blind.
- m. Payments from passengers in a car pool.
- n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o. Rescinded IAB 10/4/00, effective 10/1/00.
- p. Rescinded IAB 10/4/00, effective 10/1/00.
- q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r. Rescinded IAB 10/4/00, effective 10/1/00.
- s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
- u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1) "b"(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.
- v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8) "c" effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)“b” shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person’s income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. “Intermittent” includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)“b” and 75.57(1)“d.”

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) “a,” “b,” and “c,” and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent’s monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent’s ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) “b”(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) “b”(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent’s dependents living in the home, when the dependents’ needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) “b”(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) “a”(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1) “f.”

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related

Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)“b”(1) through (7). Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)“b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) Budgeting process.

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4) "d" and "e" is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4) "c" is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9) "i."

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8) "b" and "c," shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or
2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)“*b*,” shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 8556B, IAB 3/10/10, effective 2/10/10; ARC 9043B, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

- (1) All dependent children who are siblings of whole or half blood or adoptive.
- (2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

- (1) The needy specified relative who assumes the role of parent.
- (2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

- a. The definitions of the basic need components are as follows:
- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
 - (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
 - (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
 - (4) Food: Including school lunches.
 - (5) Clothing: Including layette, laundry, dry cleaning.
 - (6) Personal care and supplies: Including regular school supplies.
 - (7) Medicine chest items.
 - (8) Communications: Telephone, newspapers, magazines.
 - (9) Transportation: Including bus fares.
- b. Special situations in determining eligible group:
- (1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) Exclusions from the eligible group. In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

- a. Siblings (of whole or half blood, or adoptive) of eligible children.
- b. Self-supporting parents of minor unmarried parents.
- c. Stepparents of eligible children.
- d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) Situations where parent's needs are excluded. In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

75.59(5) Situations where child's needs, income, and resources are excluded. In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

441—75.61 to 75.69 Reserved.

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI). Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using "modified adjusted gross income" (MAGI) and "household income" pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing. From January 1, 2014, through June 30, 2014, subject to a waiver of the requirements of 42 U.S.C. § 1396a(e)(14) by the federal Centers for Medicare and Medicaid Services, use of MAGI and "household income" shall not be considered to be required by that section for persons otherwise eligible for family planning services under subrule 75.1(41).

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1212C, IAB 12/11/13, effective 1/1/14; ARC 1356C, IAB 3/5/14, effective 4/9/14]

441—75.71(249A) Income limits. Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program and Child Medical Assistance Program	441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931	1	\$447
		2	\$716
		3	\$872
		4	\$1,033
		5	\$1,177
		6	\$1,330
		7	\$1,481
		8	\$1,633
		9	\$1,784
		10	\$1,950
		over 10	\$1,950 plus \$178 for each additional person
Mothers and Children, for pregnant women and for infants under one year of age	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		375% of the federal poverty level for the household
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		167% of the federal poverty level for the household
Medicaid for Independent Young Adults	441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)		254% of the federal poverty level for the household

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CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

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

79.1(1) Types of reimbursement.

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

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

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

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 23 percent of other costs. Other costs include: professional staff – direct salaries, other – direct salaries, benefits and payroll taxes associated with direct salaries, mileage and automobile rental, agency vehicle expense, automobile insurance, and other related transportation.

2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

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

4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

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

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

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

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider’s actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

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

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

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

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

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$51.08 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		<p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.</p> <p>Except as noted, limits apply to all waivers that cover the named provider.</p>
1. Adult day care	Fee schedule	<p>Effective 7/1/13, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate: Veterans Administration contract rate or \$1.45 per 15-minute unit, \$23.24 per half day, \$46.26 per full day, or \$69.37 per extended day if no Veterans Administration contract.</p> <p>Effective 7/1/13, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/13 rate, \$1.94 per 15-minute unit, \$30.96 per half day, \$61.80 per full day, or \$78.80 per extended day.</p>
2. Emergency response system:		
Personal response system	Fee schedule	<p>Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.</p>
Portable locator system	Fee schedule	<p>Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.</p>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%. For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit. For intellectual disability waiver effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3% or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to an hourly rate.
	For AIDS/HIV and health and disability waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and health and disability waivers effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$87.12 per visit.
6. Respite care when provided by: Home health agency: Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Home care agency: Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Nonfacility care: Specialized respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.87 per 15-minute unit, not to exceed \$311.97 per day.
Basic individual respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.73 per 15-minute unit, not to exceed \$311.97 per day.
Group respite	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed \$311.97 per day.
Adult day care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$8.67 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.
14. Senior companion	Fee schedule	Effective 7/1/13 for non-county contract: Provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$1.87 per 15-minute unit.
15. Consumer-directed attendant care provided by: Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.30 per 15-minute unit, not to exceed \$122.62 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/13, \$3.54 per 15-minute unit, not to exceed \$82.53 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 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.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.34 per 15-minute unit.
Group	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee for service with cost settlement. See 79.1(1) "d."	For brain injury and elderly waivers: Retrospective cost-settled rate.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	For intellectual disability and brain injury waiver effective 7/1/13: \$9.19 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$955.00 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit. Maximum of 104 units per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: \$9.19 per 15-minute unit for all activities other than personal care and services in an enclave setting. \$5.20 per 15-minute unit for personal care. \$1.63 per 15-minute unit for services in an enclave setting. \$3,029.62 per month for total service. Maximum of 160 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$11.34 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$11.33 per 15-minute unit.
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 7/1/13: Lesser of provider's rate in effect 6/30/13 plus 3%, \$50.66 per day or \$13.87 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/13: Lesser of maximum Medicare rate in effect 6/30/13 plus 3%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/13 plus 3%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$3.45 per 15-minute unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13: Not to exceed the maximum ICF/ID rate per day plus 3%.
26. Day habilitation	Fee schedule	Effective 7/1/13: County contract rate converted to a 15-minute or daily rate or, in the absence of a contract rate, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute or daily rate. If no 6/30/13 rate: \$3.47 per 15-minute unit or \$67.55 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$9.19 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$24.60 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$15.91 per hour.
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7)"b," the payment rate must be based on 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.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 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.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 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.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.75 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	See 79.1(24) "d"	Retrospective cost-settled rate.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation	See 79.1(24) "d"	Effective 7/1/13: \$13.47 per hour or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	See 79.1(24) "d"	\$909 per unit (job placement). Maximum of two units per 12 months.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Enhanced job search	See 79.1(24) "d"	Effective 7/1/13: Maximum of \$8.75 per 15-minute unit and 104 units per 12 months.
Supports to maintain employment	See 79.1(24) "d"	Effective 7/1/13: \$1.55 per 15-minute unit for services in an enclave setting; \$4.95 per 15-minute unit for personal care; and \$8.75 per 15-minute unit for all other services. Total not to exceed \$2,883.71 per month. Maximum of 160 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11) "r."	Effective 7/1/13: Medicare LUPA rates in effect on July 1, 2013, updated July 1 every two years.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14) "d")
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1) "g" and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) "c"	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1) “1” and (2) “1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1) “2” and (2) “2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11) “r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) “a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7) “c”	Rate provided by 79.1(7) “c”

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Provider-specific fee schedule as determined by the Iowa Plan for Behavioral Health contractor	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)“d.”	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

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

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

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

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

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

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

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

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

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

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

“*Case-mix adjusted*” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating

the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

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

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

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

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

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

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

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

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

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

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

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate

exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)“y”(7).)

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

“*Disproportionate share rate*” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

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

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

“*Full DRG transfer*” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“*GME/DSH fund implementation year*” means 2009.

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

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

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“*Inlier*” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

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

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

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients

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

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

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

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

“*Neonatal intensive care unit*” shall mean a designated level II or level III neonatal unit.

“*Net discharges*” shall mean total discharges minus transfers and short stay outliers.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

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

“*Rebasing*” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“*Rebasing implementation year*” means 2008 and every three years thereafter.

“*Recalibration*” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

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

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

(1) Substance abuse units certified pursuant to 79.1(5)“r.” Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

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

(2) Neonatal intensive care units certified pursuant to 79.1(5)“r.” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization.

The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

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

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

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

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

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

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

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical

rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

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

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

e. Add-ons to the base amount.

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

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

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

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

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

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

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

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

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

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

g. Billing for patient transfers and readmissions.

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

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

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

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

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

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

(2) Rescinded IAB 5/12/93, effective 7/1/93.

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

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state’s fiscal year.

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

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

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

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

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

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

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

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

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

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

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5)“y,” for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

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

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

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

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph “f.”

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

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

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

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

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

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

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

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

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

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

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)"b"(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit

pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

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

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. *Health care access assessment inflation factor.* Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

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

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

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

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

t. *Limitations and application of limitations on payment.* Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

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

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

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

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

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

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

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

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

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

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

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

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

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

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

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

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

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

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

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

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical

education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

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

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

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

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

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

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

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

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

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

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

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

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

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

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

Present on Admission (POA) Indicator Codes

Code Explanation

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

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health

and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

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

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

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

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

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

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

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5) “y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

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

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2) “e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. Rescinded IAB 10/30/13, effective 1/1/14.

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7) “c”). Primary care services furnished on or after January 1, 2015, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7) “c”).

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

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

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

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

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

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

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

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

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

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

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

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

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

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

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

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

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

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

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

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

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

(1) The estimated acquisition cost, defined:

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

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

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

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

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

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

(1) The estimated acquisition cost, defined:

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

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

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

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

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“*k*,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“*j*.”

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

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

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

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“*k*,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“*j*.”

- (2) The submitted charge, representing the provider's usual and customary charge for the drug.
- e.* No payment shall be made for sales tax.
- f.* All hospitals that wish to administer vaccines which are available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.
- g.* Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)"c," whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8)"a" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.
- h.* An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.
- i.* Rescinded IAB 6/11/14, effective 8/1/14.
- j.* The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.
- k.* For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies' average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.
- l.* For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."
- m.* Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.
- n.* Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II "J" codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).
- 79.1(9) HCBS consumer choices financial management.**
- a. Monthly allocation.* A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)"b," 78.37(16)"b," 78.38(9)"b," 78.41(15)"b," 78.43(15)"b," or 78.46(6)"b."
- b. Cost settlement.* The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.
- c. Start-up grants.* A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

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

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

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

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part

B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

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

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

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

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

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

d. The member shall pay \$3 copayment for:

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

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

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

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

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

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

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

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

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

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

(2) Serious impairment to bodily functions, or

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

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

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

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

79.1(14) Reimbursement for hospice services.

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

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

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

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

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

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

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

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

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the

hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

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

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

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

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

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

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) 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 noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

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

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

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

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

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

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

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

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

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

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

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

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

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

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

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

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

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

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

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

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“*GME/DSH fund implementation year*” means 2009.

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

“*Healthcare common procedures coding system*” or “*HCPCS*” means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

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

“*International classifications of diseases—fourth edition, ninth revision (ICD-9)*” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

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

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

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

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

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

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

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

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

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments

for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

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

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

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

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

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

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

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

c. Payment for outpatient hospital services.

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

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

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

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

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

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPSS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPSS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

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

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

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

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

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

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

3. The total calculated Medicaid cost for ambulance services.

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

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

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

f. Calculation of statewide base APC rate.

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

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

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

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

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

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

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

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

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

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

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

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

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

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

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

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

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

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

j. Rebasing.

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

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

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

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

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

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

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

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

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

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

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

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

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

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

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

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

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

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

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

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

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

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

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

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

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

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

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

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

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

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

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

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

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

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

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

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

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

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

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

79.1(22) Medicare crossover claims for inpatient and outpatient hospital services. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Crossover claim*” means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital 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 prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicaid reimbursement*” means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

“*Medicare payment amount*” means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(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 shall 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 shall be 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.

79.1(23) Reimbursement for remedial services. Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each

provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

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

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for case management, job development, and employer development services provided prior to July 1, 2013, is based on a fee schedule developed using the methodology described in paragraph 79.1(1)“d.” Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment services provided prior to July 1, 2013, is based on a retrospective cost-related rate calculated using the methodology in paragraphs 79.1(24)“b” and “c.” Reimbursement for all home- and community-based habilitation services provided on or after July 1, 2013, shall be as provided in paragraph 79.1(24)“d.” All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period

as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

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

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

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

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

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

2. A 15-minute unit for enhanced job search.

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

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

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

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24)"b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

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

d. Reimbursement for services provided on or after July 1, 2013.

(1) For dates of services July 1, 2013, through December 31, 2013, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the fee schedule or interim rate for the service and the provider in effect on June 30, 2013, with no retrospective adjustment or cost settlement. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24) "b," the Iowa Plan for Behavioral Health contractor shall reduce the provider's reimbursement rate to 76 percent of the rate in effect on June 30, 2013. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

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

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

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

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

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

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

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

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

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

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

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

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

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

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

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

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

79.1(26) Home health services.

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

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

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

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

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

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

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

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

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

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

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

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

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension .xls or .xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be e-mailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

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

1. The reduced rate(s) 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 IME provider cost audit and rate setting unit.

2. The reduced rate(s) 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 IME provider cost audit and rate setting unit.

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

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

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

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

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

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

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

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

c. Terminated home health agencies.

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

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity.

If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9966B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

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

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

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

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

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

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

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

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

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

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

- a.* Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.
- b.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.
- c.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.
- d.* Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.
- e.* Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.
- f.* Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.
- g.* Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.
- h.* Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.
- i.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.
- j.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.
- k.* Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.
- l.* Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.
- m.* Failing to meet standards required by state or federal law for participation, including but not limited to licensure.
- n.* Exclusion from Medicare or any other state or federally funded medical assistance program.
- o.* Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.
- p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime

of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.

- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

- a.* The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

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

- a.* Seriousness of the offense.
- b.* Extent of violations.
- c.* History of prior violations.
- d.* Prior imposition of sanctions.
- e.* Prior provision of provider education (technical assistance).
- f.* Provider willingness to obey program rules.
- g.* Whether a lesser sanction will be sufficient to remedy the problem.
- h.* Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

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

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

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

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

79.2(7) Notice of violation.

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7) "c" for appeals certified for hearing under this chapter.

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

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

79.2(9) Civil monetary penalties and interest. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

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

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

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.

- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

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

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

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

79.3(1) Financial (fiscal) records.

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

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
 - (2) Support each item of service for which a charge is made to the medical assistance program.
- These records include financial records and other records as may be necessary for reporting and accountability.

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

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

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

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

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

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. *Components.*

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

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

and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

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

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)“c” or “d,” 441—paragraph 77.33(6)“d,” 441—paragraph 77.34(5)“d,” 441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

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

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2)“b.”)

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.

- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.

3. Laboratory reports.
4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.

2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (34) Early access service coordinator services:
 1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.

4. Prior authorization documentation.
5. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
- (40) Health home services:
 1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- e. Corrections.* A provider may correct the medical record before submitting a claim for reimbursement.

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

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

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

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

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

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

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

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

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided.

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

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

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

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting.

Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

(1) Recommendations on the reimbursement for medical services rendered by providers of services.

(2) Identification of unmet medical needs and maintenance needs which affect health.

(3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

(4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

(5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

(1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and

(2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7) “*b*,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7) “*a*,” medical assistance funds are not incorrectly paid when an individual who serves as a member’s legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320. [ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient’s admitting physician, the physician’s designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

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

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical

procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

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

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

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers other than managed care organizations and Medicaid fiscal agents shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.
2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) "a"(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) "c." Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term "direct or indirect affiliation" includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

(1) A compensation arrangement;

(2) An ownership arrangement;

(3) Managerial authority over any member of the affiliation;

(4) The ability of one member of the affiliation to control or influence any other; or

(5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years,

pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider’s application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise’s approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not

limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 1153C**, IAB 10/30/13, effective 1/1/14; **ARC 1695C**, IAB 10/29/14, effective 1/1/15]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

- (1) The laws described in paragraph 79.15(1) “a”;
- (2) The rights of employees to be protected as whistle blowers; and
- (3) The entity’s policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

- (1) The name, address, and national provider identification numbers under which the entity receives payment;
- (2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and
- (3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

- (1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or
- (2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

- (1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or
- (2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

- a.* The provider must be currently enrolled as an Iowa Medicaid provider.
- b.* The provider must be one of the following:

- (1) An eligible professional, listed as:
 1. A physician,
 2. A dentist,
 3. A certified nurse midwife,
 4. A nurse practitioner, or
 5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.
- (2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.
- (3) A children's hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.
- c. For the year for which the provider is applying for an incentive payment:
 - (1) An acute care hospital must have 10 percent Medicaid patient volume.
 - (2) An eligible professional must have at least 30 percent of the professional's patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation Web site, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration Web site at www.imeincentives.com. The applicant shall use the Web site to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation Web site.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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◊ Two or more ARCs

¹ Effective date of 79.1(2) and 79.1(5)“t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

- ² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁴ 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.
- 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**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

PREAMBLE

Inpatient psychiatric services are provided in three types of psychiatric facilities in addition to general hospitals with psychiatric units: acute care psychiatric hospitals, psychiatric medical institutions for children, and nursing facilities for the mentally ill. Except for services in the state mental health institutes, Medicaid covers only persons under the age of 21 and persons aged 65 and older in acute care psychiatric hospitals. Medicaid covers only persons under the age of 21 in psychiatric medical institutions for children, and only persons aged 65 and older in nursing facilities for the mentally ill. These rules establish conditions of participation for providers, record-keeping requirements, reimbursement methodologies, and client eligibility requirements.

DIVISION I
PSYCHIATRIC HOSPITALS

441—85.1(249A) Acute care in psychiatric hospitals. These rules do not apply to general hospitals with psychiatric units.

85.1(1) *Psychiatric hospitals serving persons aged 21 and older.* A psychiatric hospital serving persons aged 21 and older shall meet the federal criteria for an institution for mental disease and shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B). An out-of-state facility shall be licensed as a psychiatric hospital, shall meet the federal criteria for an institution for mental disease, and shall be certified to participate in the Medicare program. An institution is an institution for mental disease only if its overall character is that of a facility established and maintained primarily for the care and treatment of persons with mental diseases. The following guidelines are used by the department in evaluating the overall character of a facility. These guidelines are all useful in identifying institutions for mental disease; however, no single guideline is necessarily determinative in any given case.

a. The facility:

- (1) Is licensed as a psychiatric facility for the care and treatment of persons with mental diseases.
- (2) Advertises or holds itself out as a facility for the care and treatment of persons with mental diseases.
- (3) Is accredited as a psychiatric facility by the Joint Commission on the Accreditation of Health Care Organizations or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals.

(4) Specializes in providing psychiatric or psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric or psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

(5) Is under the jurisdiction of the division of behavioral, developmental, and protective services for families, adults, and children of the department.

b. More than 50 percent of all the patients in the facility have mental diseases which require inpatient treatment according to the patient's medical records.

c. A large proportion of the patients in the facility has been transferred from a state mental institution for continuing treatment of their mental disorders.

d. Independent review teams report a preponderance of mental illness in the diagnoses of the patients in the facility.

e. The average patient age is significantly lower than that of a typical nursing home.

f. Part or all of the facility consists of locked wards.

85.1(2) *Psychiatric hospitals serving persons under the age of 21.* A psychiatric hospital serving persons under the age of 21 shall be licensed pursuant to department of inspections and appeals rule 481—51.36(135B) or shall be licensed in another state as a hospital, shall be accredited by the Joint

Commission on the Accreditation of Health Care Organizations, the Commission of Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other federally recognized accrediting organization that has comparable standards or surveys and is approved by the department of inspections and appeals, and shall meet federal service requirements.

441—85.2(249A) Out-of-state placement. Placement in an out-of-state psychiatric hospital for acute care requires prior approval by the bureau of managed care and clinical services and shall be approved only if special services are not available in Iowa facilities as determined by the division of behavioral, developmental, and protective services for families, adults, and children.

441—85.3(249A) Eligibility of persons under the age of 21.

85.3(1) Age. To be eligible for payment for the cost of care provided by a psychiatric hospital, the person shall be under 21 years of age. When treatment in the hospital is provided immediately preceding the person's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.3(2) Period of eligibility. The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status the eligible person is entitled to the full scope of Medicaid benefits.

85.3(3) Certification of need for care. For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person's situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient's admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.3(4) Financial eligibility for persons under the age of 21. To be eligible for payments for the cost of care provided by a psychiatric facility, persons under the age of 21 must be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.4(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by an institution for mental disease, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A).

441—85.5(249A) Client participation.

85.5(1) Before July 2005. For months before July 2005, the resident shall be liable to pay client participation toward the cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

85.5(2) *July 2005 and after.* Effective with the month of July 2005, the resident shall not be liable to pay client participation toward the cost of care, and no client participation amount shall be deducted from the state payment to the hospital.

441—85.6(249A) Responsibilities of hospitals.

85.6(1) *Medical record requirements.* The medical records maintained by the psychiatric hospital shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the hospital.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within 60 hours of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires acute psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care general hospital, or enters the facility after 30 consecutive days of visitation.

85.6(2) Fiscal records.

a. 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, is hospitalized in a general hospital, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.6(3) Additional requirements. Additional requirements are mandated for persons under the age of 21.

a. *Active treatment.* Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. *Individual plan of care.* An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph "c" below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. *Interdisciplinary team.* The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.7(249A) Psychiatric hospital reimbursement.

85.7(1) Reimbursement formula. Acute care in psychiatric hospitals shall be reimbursed on a per diem rate based on Medicare principles.

a. The reimbursement principles follow and comply with the retrospective Principles of Medicare reimbursement found in Title 18 of the Social Security Act and amendments to that Act, Medicare regulations found in the Health Insurance Regulation Manual (HIRM-1), and General Instructions-Health Insurance Manual sections 10, 11, 12 and 15 when applicable.

b. Allowable costs are those defined as allowable in 42 CFR, Subpart A, Sections 413.5 and 413.9, as amended to December 2, 1996, and 42 CFR 447.250 as amended to September 23, 1992. Only those costs are considered in calculating the Medicaid inpatient reimbursement.

c. Medicare and Medicaid principles of reimbursement require hospitals to be paid at the lower of customary charges or reasonable cost and to adhere to all Medicare cost principles in the calculation of the facility rates.

d. Payment for inpatient hospital care for recipients for whom the PRO has determined that the level of care that is medically necessary is only that of skilled care or nursing care will be made at a rate equal to the statewide average Medicaid skilled nursing facility rate or the average state nursing facility rate. Periodic PRO determinations of the need for continuing care are also required.

e. Each participating Medicaid provider shall file a CMS 2552 Medicare Cost Report or a substitute accepted by the Centers for Medicare and Medicaid Services. In addition, supplemental information sheets are furnished to all Medicaid providers to be filed with the annual cost report. This report must be filed with the Iowa Medicaid enterprise provider audits and rate-setting unit for Iowa within 150 days after the close of the hospital's fiscal year.

f. Compensation for a disproportionate share of indigent patients is determined as described in 441—subrule 79.1(5).

g. Medicaid reimbursement shall be reduced by any payments from a third party toward the cost of a patient's care.

85.7(2) *Medical necessity.* The medical necessity of admission and continued stay will be determined by the PRO. Payment shall not be made for admissions which are determined not to be medically necessary nor will payment be approved for stays beyond the time at which inpatient specialized hospital care at the acute level has been determined not to be medically necessary.

85.7(3) *Reserve bed day payment.* No reserve bed day payments are made to acute care psychiatric hospitals.

85.7(4) *Outpatient services.* No coverage is available for outpatient psychiatric hospital services. These rules are intended to implement Iowa Code section 249A.4.

441—85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64.

85.8(1) *Facility.* Acute care in a psychiatric hospital is covered for persons aged 21 through 64 only at the state mental health institutes at Cherokee, Clarinda, Independence, and Mount Pleasant.

85.8(2) *Basis of eligibility.* To be eligible for payment for the cost of care provided by one of the covered facilities, a person aged 21 through 64 must be either:

a. Eligible for one of the coverage groups listed in 441—75.1(249A); or

b. Eligible under the IowaCare program pursuant to 441—Chapter 92.

85.8(3) *Period of eligibility.* A person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of discharge.

85.8(4) *Extent of eligibility.*

a. While on inpatient status, a person eligible under a coverage group listed in 441—75.1(249A) is entitled to the full scope of Medicaid benefits.

b. While on inpatient status, a person eligible under the IowaCare program is entitled to the services listed at 441—92.8(249A,81GA,ch167).

441—85.9 to 85.20 Reserved.

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

441—85.21(249A) Conditions for participation. Psychiatric medical institutions for children shall be issued a license by the department of inspections and appeals under Iowa Code chapter 135H and shall hold either a license from the department of human services under Iowa Code section 237.3, subsection 2, paragraph “a,” subparagraph (3) or, for facilities which provide substance abuse treatment, a license from the department of public health under Iowa Code section 125.13.

This rule is intended to implement Iowa Code sections 135H.4 and 249A.4.

441—85.22(249A) Eligibility of persons under the age of 21.

85.22(1) Age. To be eligible for payment for the cost of care provided by a psychiatric medical institution for children, the person shall be under 21 years of age. When treatment in the facility is provided immediately preceding the individual’s twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier.

85.22(2) Period of eligibility. The person is considered to be an inpatient until unconditionally discharged. Coverage extends until the last day of the month of the discharge or the twenty-second birthday. While on inpatient status, the eligible individual is entitled to the full scope of Medicaid benefits.

85.22(3) Certification for need for care. For persons eligible for Medicaid prior to admission, an independent team shall certify that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed. Team members are independent when they are not employees of or consultants to the facility. Form 470-2780, Certification of Need for Inpatient Psychiatric Services, may be used to document these criteria.

a. For persons determined eligible for Medicaid prior to admission, this preadmission certification shall be performed within 45 days prior to the proposed date for admission to the facility by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and who has knowledge of the person’s situation. If a social worker is a part of the team, the social worker may be from the county office of the department of human services.

The evaluation shall be submitted to the facility on or prior to the date of the patient’s admission.

b. When a person makes application for Medicaid subsequent to admission or has an application in process at the time of admission, a certification by the team responsible for the plan of care shall be provided within 14 days after admission and shall cover any period prior to application for which claims are to be made.

c. For emergency admissions, a certification shall be provided by the team responsible for the plan of care within 14 days after admission.

85.22(4) Financial eligibility for persons under the age of 21. To be eligible for payments for the cost of care provided by psychiatric medical institutions, persons under the age of 21 shall be eligible under one of the coverage groups listed in rule 441—75.1(249A), except medically needy.

441—85.23(249A) Client participation. The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.24(249A) Responsibilities of facilities.

85.24(1) Medical record requirements. The medical records maintained by psychiatric medical institutions for children shall permit determination of the degree and intensity of the treatment provided to persons who are furnished services in the facility.

a. Development of assessment and diagnostic data. Medical records shall stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is admitted.

(1) The identification data shall include the patient's legal status.

(2) A provisional or admitting diagnosis shall be made on every patient at the time of admission, and shall include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

(3) The reasons for admission shall be clearly documented as stated by the patient or others significantly involved.

(4) The social service records, including reports of interviews with patients, family members, and others, shall provide an assessment of home plans and family attitudes and community resource contacts, as well as a social history.

(5) When indicated, a complete neurological examination shall be recorded at the time of the admission physical examination.

b. Psychiatric evaluation. Each patient shall receive a psychiatric evaluation that shall:

(1) Be completed within seven days of admission.

(2) Include a medical history.

(3) Contain a record of mental status.

(4) Note the onset of illness and the circumstances leading to admission.

(5) Describe attitudes and behavior.

(6) Estimate intellectual functioning, memory functioning, and orientation.

(7) Include an inventory of the patient's assets in descriptive, not interpretive, fashion.

c. Treatment plan.

(1) Each patient shall have an individual comprehensive treatment plan that shall be based on an inventory of the patient's strengths and disabilities. The written plan shall include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

(2) The treatment received by the patient shall be documented in a way to ensure that all active therapeutic efforts are included.

d. Recording progress. Progress notes shall be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but shall be recorded at least weekly for the first two months and at least once a month thereafter and shall contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

e. Discharge planning and discharge summary. The record of each patient who has been discharged shall have a discharge summary that includes a recapitulation of the patient's stay at the facility and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

f. The facility shall obtain a professional review organization (PRO) determination that the person requires psychiatric medical institution level of care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.24(2) Fiscal records.

a. 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, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

85.24(3) Additional requirements. Additional requirements are mandated for persons under the age of 21.

a. Active treatment. Inpatient psychiatric services shall involve active treatment. Active treatment means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team no later than 14 days after admission and is designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

b. Individual plan of care. An individual plan of care is a written plan developed for each recipient to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan shall be reviewed every 30 days by the team to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. The plan of care shall:

(1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.

(2) Be developed by a team of professionals, as specified in paragraph "c" below, in consultation, if possible, with the recipient and the recipient's parents, legal guardians or others in whose care the recipient will be released after discharge.

(3) State the treatment objectives.

(4) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives.

(5) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

c. Interdisciplinary team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or who provide services to patients in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are involved in the direct provision of treatment services, involved in the organization of the plan of care, or involved in consulting with or supervising those professionals involved in the direct provision of care.

(1) Based on education and experience, preferably including competence in child psychiatry, the team shall be capable of assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; assessing the potential resources of the recipient's family; setting treatment objectives; and prescribing therapeutic modalities to achieve the plan's objectives.

(2) The team shall include, as a minimum, either a board-eligible or board-certified psychiatrist, a clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

(3) The team shall also include one of the following: a social worker with a master's degree in social work with specialized training or one year's experience in treating persons with mental illness, a registered nurse with specialized training or one year's experience in treating persons with mental illness, an occupational therapist who is licensed and who has specialized training or one year of experience in treating persons with mental illness, or a psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

441—85.25(249A) Reimbursement to psychiatric medical institutions for children.

85.25(1) *Computation of inpatient rate for non-state-owned facilities prior to July 1, 2014, and for state-owned facilities.* For services rendered by non-state-owned facilities on or before June 30, 2014, or by state-owned facilities, facilities are paid at a per diem rate based on the facility's actual and allowable cost for the service not to exceed the upper limit as provided in 441—subrule 79.1(2).

a. Rates for new facilities are based on historical costs submitted on Form 470-0664, Financial and Statistical Report for Purchase of Service Contracts, if the institution is established and has the historical data. If the institution is newly established, the rate shall be based on a proposed budget submitted on

Form 470-0664. A Form 470-0664 with actual cost data shall be submitted after at least six months of participation in the program for a new rate adjustment.

b. After the initial cost report period, the institution shall submit Form 470-0664 annually within three months of the close of the facility's fiscal year. Failure to submit the report within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

c. For services rendered on or after August 1, 2011, rates paid shall be adjusted to 100 percent of the facility's actual and allowable average costs per patient day, based on the cost information submitted pursuant to paragraphs 85.25(1) "a" and "b," subject to the upper limit provided in 441—subrule 79.1(2) for non-state-owned facilities. Before rate adjustment, providers shall be paid a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

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

85.25(3) *Reserve bed payments.*

a. Reserve bed day payment for days a resident of a psychiatric medical institution for children is absent from the facility for hospitalization in an acute care general hospital is paid in accordance with the following policies:

(1) The intent of the department and the facility shall be for the resident to return to the facility after the hospitalization.

(2) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the hospitalization.

(3) Payment for reserve bed days shall be canceled and payment returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment will not be authorized for over ten days per calendar month and will not be authorized for over ten days for any continuous hospital stay.

b. Reserve bed days for visitation shall be made for days a resident is absent from a psychiatric medical institution for children at the time of a nightly census for the purpose of visitation when the absence is in accordance with the following policies:

(1) The visits are consistent with the child's case permanency plan and the facility's individual case plan.

(2) The intent of the department and the facility shall be for the child to return to the facility after the visitation.

(3) Staff from the psychiatric medical institution shall be available to provide support to the child and family during the visit.

(4) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment for reserve bed days shall be canceled effective the day after a decision not to return the child is made by the court or, in a voluntary placement, by the parent.

(6) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

c. Reserve bed payment shall be made for days a resident is absent from a psychiatric medical institution for children at the time of the nightly census for reasons such as detention, shelter care, or running away when the absence is in accordance with the following policies:

(1) The intent of the department and the psychiatric medical institution for children shall be for the child to return to the facility after the absence.

(2) Payment for reserve bed days shall be canceled and payments returned if the facility refuses to accept the child back except when the department and the facility agree that the return would not be in the child's best interests. If the department and the facility agree that the return would not be in the child's best interests, payment shall be canceled effective the day after the joint decision not to return the child.

(3) Payment for reserve bed days shall be canceled effective the day after a decision is made not to return the child by the court or, in a voluntary placement, by the parent.

(4) Payment for reserve bed days shall not exceed 14 consecutive days or 30 days per year, except upon written approval of the regional administrator. In no case shall payment exceed 60 days per year for visitation or other absences.

(5) Reserve bed day payment is not available until the child has been physically admitted to the psychiatric medical institution.

(6) The psychiatric medical institution shall notify the department social worker within 24 hours after the child is out of the facility for running away or other unplanned reasons.

85.25(4) Day treatment rates. Outpatient day treatment services are paid on a fixed fee basis. [ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 2026C, IAB 6/10/15, effective 8/1/15]

441—85.26(249A) Outpatient day treatment for persons aged 20 or under. Payment to a psychiatric medical institution for children will be approved for day treatment services for persons aged 20 or under if the psychiatric medical institution for children is certified by the department of inspections and appeals for day treatment services and the services are provided on the licensed premises of the psychiatric medical institution for children.

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. All conditions for the day treatment program for persons aged 20 or under as outlined in 441—subrule 78.16(7) for community mental health centers shall apply to psychiatric medical institutions for children.

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

441—85.27 to 85.40 Reserved.

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

441—85.41(249A) Conditions of participation. A nursing facility for persons with mental illness shall be licensed pursuant to department of inspections and appeals rules 481—Chapter 65, or, if the facility is a distinct part of a hospital, pursuant to department of inspections and appeals rule 481—51.33(135B). A distinct part of a general hospital may be considered a psychiatric institution. In addition, the facility shall be certified to participate in the Iowa Medicaid program as a nursing facility pursuant to 441—Chapter 81 and shall be 16 beds or more. The facility shall also meet the criteria set forth in subrule 85.1(1).

441—85.42(249A) Out-of-state placement. Placement in out-of-state nursing facilities for persons with mental illness is not payable.

441—85.43(249A) Eligibility of persons aged 65 and over. To be eligible for payment for the cost of care provided by nursing facilities for persons with mental illness, persons must be aged 65 or over and be eligible under one of the coverage groups listed in rule 441—75.1(249A), except for medically needy.

441—85.44(249A) Client participation. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the resident for payment of client participation. Client participation is determined according to rule 441—75.16(249A).

441—85.45(249A) Responsibilities of nursing facility.

85.45(1) Medical record requirements. The facility shall obtain a PRO determination that the person requires psychiatric care when a person applying or eligible for Medicaid enters the facility, returns from an acute care hospital stay longer than 10 days, or enters the facility after 30 consecutive days of visitation. Periodic PRO determinations of the need for continuing care are also required.

85.45(2) Fiscal records.

a. 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, is hospitalized, leaves for visitation, or is discharged from the facility.

b. The facility shall bill after each calendar month for the previous month's services.

441—85.46(249A) Policies governing reimbursement. Cost reporting, reserve bed day payment, and reimbursement shall be the same for nursing facilities for persons with mental illness as for nursing facilities as set forth in 441—Chapter 81.

441—85.47(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental illness 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 Supplement section 249A.30A.

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

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CHAPTER 88
MANAGED HEALTH CARE PROVIDERS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health), and programs of all-inclusive care for the elderly (PACE). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

“*Capitation rate*” shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

“*Contract*” shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“*Covered services*” shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

“*Department*” shall mean the Iowa department of human services.

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

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

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

“*Enrollment area*” shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

“*Extended-participation program*” shall mean a mandatory six-month enrollment period with a managed care entity.

“*Federally qualified HMO*” shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

“*Grievance*” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

“*Health maintenance organization (HMO)*” shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“*Managed health care review committee*” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“*Mandatory enrollment*” shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

“*Mandatory project county*” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“*Noncovered services*” shall mean services covered under Medicaid which are not included in the HMO’s contract with the department. Payment for these services will be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

“*Recipient*” shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

“*Region*” shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

“*Routine care*” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent care*” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“*Urgent medical condition*” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

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

441—88.2(249A) Participation.

88.2(1) Contracts with HMOs. The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules of the insurance division, 191—Chapter 40. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with HMOs.

- a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.2(2) *Method of selection of HMO.* In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

a. *Request for proposal.* Rescinded IAB 11/10/93, effective 11/1/93.

b. *Minimum contract requirements.* Rescinded IAB 11/10/93, effective 11/1/93.

88.2(3) *Termination of contract.* The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

a. The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

b. The HMO's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of financial solvency on the part of the HMO.

d. There is not substantial compliance with all provisions of the contract.

e. The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.2(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

- b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
 - c. Recipients who are supplemental security income-related case members.
 - d. Rescinded IAB 10/3/01, effective 12/1/01.
 - e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
 - f. Recipients who are foster care and subsidized adoption-related case members.
 - g. Recipients who are Medicare beneficiaries.
 - h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
 - i. Recipients who are Native American Indians or Alaskan natives.
 - j. Recipients who are receiving services from a Title V provider.
- [ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—88.3(249A) Enrollment.

88.3(1) *Enrollment area.* Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

88.3(2) *Voluntary enrollment.* When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

88.3(3) *Mandatory enrollment.* Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.3(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4) "b." The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

88.3(5) *Identification card.* The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

88.3(6) *Limitations on enrollment.* Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment

in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

88.3(7) Enrollment procedures. In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

c. Selection of a managed health care provider. A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

e. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."

- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) “b.”
 - (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.
- f. Enrollment cycle.* Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

441—88.4(249A) Disenrollment.

88.4(1) Disenrollment request. Rescinded IAB 5/6/98, effective 7/1/98.

88.4(2) Effective date. Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.4(3) Disenrollment process. The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

a. Request for disenrollment by the recipient. The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

b. Request for disenrollment by the HMO. With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

- (1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.
- (2) There is evidence of unauthorized use of the HMO identification card.
- (3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or “drop-in” requests for service without making appointments.

88.4(4) Disenrollments by the department. Disenrollments will occur when:

- a.* The contract between the department and the HMO is terminated.
- b.* The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.
- c.* The recipient permanently moves outside the HMO’s enrollment area.
- d.* The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

f. The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

88.4(5) *No disenrollment for health reasons.* No recipient will be disenrolled from an HMO because of an adverse change in health status.

441—88.5(249A) Covered services.

88.5(1) *Amount, duration, and scope of services.* Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

a. The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

b. To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

88.5(2) *Required services.*

a. The HMO shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.
- (7) Laboratory and X-ray services.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.
- (10) Optometric and ophthalmology services.
- (11) Clinic services.
- (12) Ambulance services.
- (13) Rescinded IAB 11/5/97, effective 1/1/98.
- (14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).
- (15) Rehabilitation agencies.

b. HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

88.5(3) *Excluded services.* Unless specifically included in the contract, HMOs will not be required to cover:

- a.* Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).
- b.* Inpatient psychiatric care provided at state-administered mental health institutes.
- c.* Services provided by the area education agencies.
- d.* Services provided at psychiatric medical institutions for children.
- e.* Dental services.
- f.* Hospice services.
- g.* Mental health services as defined in rule 441—88.65(249A).
- h.* Rescinded IAB 8/1/07, effective 9/5/07.
- i.* Psychiatric services.
- j.* Infant and toddler program services.
- k.* Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

88.5(4) *Restrictions and limitations.* If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

88.5(5) *Recipient use of HMO services.* A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

441—88.6(249A) Emergency and urgent care services.

88.6(1) *Availability of services.* The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

88.6(2) *HMO payment liability.* HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.6(3) *Notification and claim filing time spans.* The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

88.6(4) *Provision of urgent care.* If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

441—88.7(249A) Access to service.

88.7(1) *Choice of provider.* Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

88.7(2) *Medical service delivery sites.* Medical service delivery sites must have the following specific characteristics:

- a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

- b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.7(3) Adequate appointment system. The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

- a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.
- b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.
- c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.
- d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.7(4) Adequate after hours call-in coverage. The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

- a. Twenty-four-hour-a-day phone coverage shall exist.
- b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.
- c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.7(5) Adequate referral system. The HMO must effect the following arrangements which provide for an adequate referral system:

- a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.
- b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.
- c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.8(249A) Grievance procedures.

88.8(1) Written procedure. The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of a grievance to the grievant.
- c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.
- d. Ensures the participation of persons with authority to require corrective action.
- e. Includes at least one level of appeal.
- f. Ensures the confidentiality of the grievant.
- g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

88.8(2) *Written record.* All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

88.8(3) *Information concerning grievance procedures.* The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

88.8(4) *Appeals to the department.* A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

88.8(5) *Periodic report to the department.* The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

88.8(6) *Consent for state fair hearing.* Network providers which are contracted and in good standing with a medical managed care organization (MCO) may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[ARC 0583C, IAB 2/6/13, effective 4/1/13]

441—88.9(249A) Records and reports.

88.9(1) *Medical records system.* The HMO shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition the HMO must maintain a medical records system which:

- a. Identifies each medical record by state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to HMOs.

88.9(2) *Content of individual medical record.* The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.9(3) *Confidentiality of records.* HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide

services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph “e” of this subrule.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).

d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or a facility requesting the information.

f. Medical records maintained by subcontractors must meet the requirements of this rule.

88.9(4) Reports to the department. Each HMO shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the HMO’s fiscal year or other additional terms as specified by the contract.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department’s discretion, vary among HMOs, depending on the services covered and other contractual differences.

88.9(5) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—88.10(249A) Marketing.

88.10(1) General requirements. An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. *Service market.* An HMO shall distribute any marketing materials to its entire service area or region.

b. *Prohibition of tie-ins.* An HMO, or any agency of the entity, may not seek to influence an individual’s enrollment with the HMO in conjunction with the sale of any other insurance.

c. *Prohibiting marketing fraud.* Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. *Prohibition of “cold-call” marketing.* HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other “cold-call” marketing of enrollment.

88.10(2) Marketing representatives. Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO’s marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

88.10(3) Marketing presentations. The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

88.10(4) *Marketing materials.* Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

441—88.11(249A) Patient education.

88.11(1) *Health education procedures.* The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

88.11(2) *Use of services.* The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

88.11(3) *Patient rights and responsibilities.* The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

441—88.12(249A) Reimbursement.

88.12(1) *Capitation rate.* In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

88.12(2) *Determination of rate.* The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.12(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

88.12(4) *Third-party liability.* If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

441—88.13(249A) Quality assurance. The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other

than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to 88.20 Reserved.

DIVISION II
PREPAID HEALTH PLANS

441—88.21(249A) Definitions.

“Capitation rate” shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

“Contract” shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“Department” shall mean the Iowa department of human services.

“Emergency service” shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient’s health.

“Enrollment area” shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

“Grievance” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

“Managed health care” shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“Managed health care review committee” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“Managed services” shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

“Nonmanaged services” shall mean medical services covered under regular Medicaid, but which are not covered in the PHP’s contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

“Participating providers” shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

“Prepaid health plan (PHP)” shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

“Recipient” shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.22(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

“Routine care” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or

health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent, nonemergency need*” shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

441—88.22(249A) Participation.

88.22(1) *Contracts with PHPs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with PHPs.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.22(2) *Method of selection of PHP.* In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

88.22(3) *Termination of contract.* Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

a. The PHP’s delivery system does not ensure enrolled recipients adequate access to medical services.

b. The PHP’s delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of solvency on the part of the PHP.

d. There is not substantial compliance with all provisions of the contract.

e. The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.22(4) Recipients eligible to enroll. Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

- a.* Recipients who are medically needy as defined at 441—subrule 75.1(35).
- b.* Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c.* Recipients who are supplemental security income-related case members.
- d.* Rescinded IAB 10/3/01, effective 12/1/01.
- e.* Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f.* Recipients who are foster care and subsidized adoption-related case members.
- g.* Recipients who are Medicare beneficiaries.
- h.* Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i.* Recipients who are Native American Indians or Alaskan natives.
- j.* Recipients who are receiving services from a Title V provider.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—88.23(249A) Enrollment.

88.23(1) Enrollment area. Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

88.23(2) Voluntary enrollment. When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

88.23(3) Mandatory enrollment. In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

88.23(4) Effective date. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

88.23(5) Identification card. The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

88.23(6) Assignment methodology. When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

a. Notification. Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

b. Limitations. Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

c. Household member enrollment. Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

d. Assigned recipients who desire another choice. Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.23(4) and 88.24(2) dealing with effective date.

441—88.24(249A) Disenrollment.

88.24(1) Disenrollment request. An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

88.24(2) Effective date. Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.24(3) Disenrollment process. If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

a. Request for disenrollment by the recipient. In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care

programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

b. Request for disenrollment by the PHP. With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

(1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.

(2) There is evidence of unauthorized use of the PHP identification card.

(3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

88.24(4) *Disenrollments by the department.* Disenrollments will occur when:

a. The contract between the department and the PHP is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.

c. The recipient permanently moves outside the PHP's enrollment area.

d. The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.21(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

88.24(5) *No disenrollment for health reasons.* No recipient shall be disenrolled from a PHP because of an adverse change in health status.

441—88.25(249A) Covered services.

88.25(1) *Amount, duration, and scope of services.* Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

88.25(2) *Mandatory services.*

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(3)), the PHP shall cover as a minimum the following services:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Family planning services.

(5) Home health agency services.

(6) Laboratory and X-ray services.

(7) Early periodic screening, diagnosis and treatment for persons under age 21.

(8) Rural health clinic services (where available).

(9) Advanced registered nurse practitioners.

b. PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

c. According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

88.25(3) *Excluded services.* Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

88.25(4) Restrictions and limitations. If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

88.25(5) Recipient use of PHP services. An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.25(2)“c,” and rule 441—88.26(249A).

441—88.26(249A) Emergency services.

88.26(1) Availability of services. The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP’s own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

88.26(2) PHP payment liability. PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP’s enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP’s enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.26(3) Notification and claim filing time span. The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

441—88.27(249A) Access to service.

88.27(1) Choice of provider. Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

88.27(2) Medical service delivery sites. Medical service delivery sites shall have the following specific characteristics:

- a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.
- b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.27(3) Adequate appointment system. The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.27(4) Adequate after hours call-in coverage. The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

a. Twenty-four-hour-a-day telephone coverage shall exist.

b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.27(5) Adequate referral system. The PHP must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.28(249A) Grievance procedures.

88.28(1) Written procedure. The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of a grievance to the grievant.

c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.

d. Ensures the participation of persons with authority to require corrective action.

e. Includes at least one level of appeal.

f. Ensures the confidentiality of the grievant.

88.28(2) Written record. All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

88.28(3) Information concerning grievance procedures. The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

88.28(4) Appeals to the department. A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

88.28(5) Periodic report to the department. The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.29(249A) Records and reports.

88.29(1) Medical records system. The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

- a. Identifies each medical record by the departmentally assigned state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.29(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to PHPs.

88.29(2) *Content of individual medical record.* The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.29(3) *Confidentiality of records.* PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.
- c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).
- d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.
- e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or facility requesting the information.
- f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

88.29(4) *Reports to the department.* Each PHP shall submit reports to the department as follows:

- a. Annual audited financial statements no later than 120 days after the close of the PHP’s fiscal year.
- b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

88.29(5) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.30(249A) Marketing.

88.30(1) *Marketing procedures.* All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

88.30(2) *Marketing representatives.* Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP’s marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which

ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

88.30(3) *Marketing presentations.* The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

88.30(4) *Marketing materials.* Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

441—88.31(249A) Patient education.

88.31(1) *Use of services.* The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

88.31(2) *Patient rights and responsibilities.* The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

441—88.32(249A) Payment to the PHP.

88.32(1) *Capitation rate.* In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

88.32(2) *Determination of rate.* The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.25(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.32(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

88.32(4) *Third-party liability.* If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment. The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

441—88.33(249A) Quality assurance. The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.34 to 88.40 Reserved.

DIVISION III
MEDICAID PATIENT MANAGEMENT**441—88.41(249A) Definitions.**

“*Contract*” shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

“*Covered eligibles*” shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

“*Department*” shall mean the Iowa department of human services.

“*Designee*” shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

“*Eligible providers*” shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

“*Emergency care*” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“*Emergent medical condition*” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

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

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“*Enrolled recipient*” shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

“*Extended-participation program*” shall mean mandatory six-month enrollment period with a managed care entity.

“*Grievance*” shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

“*Managed health care review committee*” shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

“*Mandatory enrollment*” shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

“*Mandatory project county*” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the

needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“Managed services” shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

“Medical service area” means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

“MediPASS” shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

“Nonmanaged services” shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

“Patient management” shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

“Patient manager” shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

“Urgent care” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“Urgent medical condition” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

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

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

441—88.42(249A) Eligible recipients.

88.42(1) *Included categories of assistance.* All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient’s county of residence shall fulfill the requirements to participate in mandatory project counties.

88.42(2) *Excluded categories of assistance.* The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

- a. Medically needy recipients as defined in 441—subrule 75.1(35).
- b. Recipients over age 65 and under age 21 in psychiatric institutions as defined in 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Automatic redetermination recipients as defined in rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).
- i. Recipients who are Native American Indians or Alaskan natives.
- j. Recipients who are receiving services from a Title V provider.

441—88.43(249A) Project area.

88.43(1) *Designation as a mandatory project county.* The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department's freedom of choice waiver from the Centers for Medicare and Medicaid Services.

88.43(2) *Voluntary project counties.* The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

88.43(3) *Expansion to other counties.* Rescinded IAB 11/10/93, effective 11/1/93.

441—88.44(249A) Eligible providers.

88.44(1) *Specialties allowed.* Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

a. Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1)“*d.*”

b. Is otherwise eligible to enroll as an Iowa Medicaid provider.

c. Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).

d. Is practicing in one of the following specialties in the medical services area:

(1) Family practice.

(2) General practice.

(3) Pediatrics.

(4) Internal medicine.

(5) Obstetrics and gynecology.

88.44(2) *Clinic or group practice participation.* A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

88.44(3) *Exceptions.* Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

a. If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient's medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2)“*c.*” the department shall contact the provider in question to offer the provider the opportunity to request the exception.

b. Rescinded IAB 11/10/93, effective 11/1/93.

c. Rescinded IAB 11/10/93, effective 11/1/93.

d. The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

e. The following factors shall be taken into account when considering the physician's request:

- (1) Mutual agreement between physician and patient regarding the arrangement.
- (2) Existence of an already established physician-patient relationship.
- (3) Transportation barriers, if requesting a patient manager outside the medical service area.
- (4) Customary practice by the specialist to provide primary care.
- (5) A new medical condition which necessitates the proposed physician-patient relationship.

441—88.45(249A) Contracting for the provision of patient management.

88.45(1) Eligibility to contract. Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

88.45(2) Contract provisions. The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

a. The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.

b. The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.

c. The patient manager shall maintain records that at a minimum:

(1) Identify the patient as a patient management recipient.

(2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.

(3) Contain the name, state identification number, age, sex and address of the patient.

(4) Document services provided and where and by whom they are provided.

(5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.

(6) Contain the name of the person making the entry and the date of the contact.

d. The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.

e. The department shall specify the fees and method of payment to patient managers.

f. The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

88.45(3) Contract compliance. The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

88.45(4) Corrective action and sanctions. The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

88.45(5) Termination of contract. The contract may be terminated in any of the following ways:

a. The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.

(1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).

(2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.

b. The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

- (1) The department has imposed any sanction described at 441—subrule 79.2(3).
- (2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

- c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

441—88.46(249A) Enrollment and changes in enrollment.

88.46(1) *Mandatory enrollment.* Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.46(2) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. MediPass patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed health care assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. Selection of a managed health care provider. A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Rescinded IAB 5/7/97, effective 7/1/97.

e. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

f. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen provider for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."
- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) "b."
- (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

g. Enrollment cycle. Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

88.46(3) Voluntary enrollment procedures. Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

- a.* Recipients shall not be informed at the face-to-face interview that enrollment is required.
- b.* Notice to recipient shall not include assignment language.
- c.* Recipients shall not be assigned if no selection is made voluntarily.
- d.* A managed health care provider must be available for enrollment.

88.46(4) Effective date. Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

88.46(5) Identification card. The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

88.46(6) Enrollment limits.

a. Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

- (1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.
- (2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.

(3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

b. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

88.46(7) Reinstatement of patient management status. When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

441—88.47(249A) Disenrollment.

88.47(1) Disenrollment request. An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1)“c” (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

88.47(2) Effective date. Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

441—88.48(249A) Services.

88.48(1) Managed services. Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

- a. Inpatient hospital.
- b. Outpatient hospital.
- c. Home health.
- d. Physician (except services provided by an ophthalmologist).
- e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).
- f. Laboratory, X-ray.
- g. Medical supplies.
- h. Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.
- i. Rescinded IAB 11/5/97, effective 1/1/98.
- j. Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

Services or parts thereof described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, require authorization by the patient manager as otherwise required by this division.

88.48(2) Nonmanaged services. Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

88.48(3) Authorizing managed services. The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager’s absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager’s Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager’s initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager’s approval, the patient manager’s number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient’s medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient

manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

88.48(4) *Special authorizations.* Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph "b."

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—88.49(249A) Grievance procedure. The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

88.49(1) *Written record.* The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

88.49(2) *Formal grievance resolution and response.* The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the recipient, the provider and to the department's patient manager file. Appeal rights shall be included in the response.

88.49(3) *Repeated grievances.* Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

88.49(4) *Quality of care grievances.* In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

88.49(5) *Information concerning grievance procedures.* The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

88.49(6) *Appeals to the department.* A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

441—88.50(249A) Payment.

88.50(1) *Fee.* Patient managers shall be paid a monthly fee of \$2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

88.50(2) *Basis for payment.* Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

88.50(3) *Mode of payment.* The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

88.50(4) Payment limit. Payment shall be limited to \$3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

441—88.51(249A) Utilization review and quality assessment. Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

88.51(1) Measured services. Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

88.51(2) Reports to patient managers. Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

88.51(3) Managed health care advisory committee. Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

a. Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.

b. Assist the department in establishing options for managed health care quality assessment.

c. Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).

d. Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.

e. Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.

f. Prepare or provide educational or informative articles to be used for patient education and health promotion.

441—88.52(249A) Marketing. A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

88.52(1) Service market. A MediPASS provider shall distribute any marketing materials to the entire service area or region.

88.52(2) Prohibition of "cold-call" marketing. MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

441—88.53 to 88.60 Reserved.

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

441—88.61(249A) Definitions.

"Accredited" shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

“*Appeal*” shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member’s designee, may request review of a certain decision made by the department or the contractor.

“*ASAM-PPC-2R*” shall mean the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised, published by the American Society of Addiction Medicine in 2001.

“*Assertive community treatment (ACT) program*” shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

“*Capitation rate*” shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

“*Certification*” shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

“*Clinical decision review*” shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

“*Contract*” shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

“*Contractor*” shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

“*Coverage group*” shall mean a category of members who meet certain common eligibility requirements.

“*Covered services*” shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

“*Department*” shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

“*Designee*” shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

“*Director*” shall mean the director of the Iowa department of human services.

“*Disenrollment*” shall mean the removal of an enrollee from the contractor’s enrollment list either through loss of eligibility or some other cause.

“*Emergency services*” shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

“*Encounter data*” shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

“*Enrollee*” shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

“*Enrollment*” shall mean the inclusion of a Medicaid member on a contractor’s Medicaid enrollment file.

“*Enrollment area*” shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

“*Fee-for-service*” shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined

services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

“Grievance” shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor’s staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

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

“Integrated mental health services and supports” shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

“Iowa Plan” shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

“Licensed” shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

“Member” shall mean a person determined eligible for Medicaid.

“Mental health services” shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9). At a minimum, covered disorders include the following ranges of the ICD-9: 290-302.9; 306-309.9; and 311-314.9. Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

“MHI” shall mean a state mental health institute operated by the department.

“Open panel” shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

“Participating providers” shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

“Prepaid health plan (PHP)” shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3), as amended to March 13, 1991.

“Prior authorization” shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

“Psychosocial necessity” shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.
3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee’s clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g.,

availability of transportation, lack of natural supports including a place to live); and the enrollee's choice of provider or treatment location.

"Required services" shall mean mental health and substance abuse treatment services and supports which are not reimbursable through the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

"Retroactive eligibility" shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

"Routine care" shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider. Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient's life without immediate intervention.

"Service necessity" shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the criteria of the ASAM-PPC-2R. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

"Substance abuse licensed PMIC" shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

"Substance abuse services" shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9), disorders 303 through 305.9, provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

"Targeted case management services" shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

"Third party" shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

"Urgent, nonemergency care" shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient's life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

441—88.62(249A) Participation.

88.62(1) Contract. The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, and Chapter 85, Division II, or any portion thereof, with a prepaid health plan.

a. The department shall also determine that the contractor meet the following additional requirements:

- (1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.

(2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.

(3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Specify the duration of the contract period.

(3) List the services which must and may be covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationships.

(8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

88.62(2) *Assessment of penalties.* Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.

b. Failure to comply with any provision of the contract.

[ARC 2026C, IAB 6/10/15, effective 8/1/15]

441—88.63(249A) Enrollment.

88.63(1) *Enrollment area.* The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

88.63(2) *Members subject to enrollment.* All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

88.63(3) *Others to be served.* The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

88.63(4) *Voluntary enrollment.* There will be no voluntary enrollment in the Iowa Plan.

88.63(5) *Effective date.* For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

88.63(6) *Medical card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

441—88.64(249A) Disenrollment.

88.64(1) *Disenrollments by the department.* Disenrollments shall occur when:

- a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.
- b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.
- c. The enrollee dies.

88.64(2) *Effective date.* Disenrollment shall be effective the first day of the month following the month of disenrollment.

88.64(3) *No disenrollment for health reasons.* No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

441—88.65(249A) Covered services.

88.65(1) *Amount, duration, and scope of services.* The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

88.65(2) *Enrollee use of Iowa Plan services.* Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

88.65(3) *Covered, required and optional mental health services.*

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

- (1) Ambulance services for psychiatric conditions.
- (2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.
- (3) Inpatient hospital care for psychiatric conditions.
- (4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.
- (5) Partial hospitalization.
- (6) Day treatment.
- (7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.
- (8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.
- (9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.
- (10) Services provided through a community mental health center.
- (11) Targeted case management services to persons with chronic mental illness.
- (12) Medication management.
- (13) Psychiatric nursing services by a home health agency.
- (14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.
- (15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- (16) Behavioral health intervention as set forth in rule 441—78.12(249A).
- (17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.
- (18) Home- and community-based habilitation services as described at rule 441—78.27(249A).

b. The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

- (1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.
- (2) Services of a licensed social worker for treatment of mental illness.
- (3) Mobile crisis services.
- (4) Mobile counseling services.
- (5) Integrated mental health services and supports.
- (6) Psychiatric rehabilitation services.
- (7) Peer support services for persons with chronic mental illness.
- (8) Community support services.
- (9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.
- (10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

88.65(4) Covered and required substance abuse services. The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

- a. Outpatient services (all Level I services according to the ASAM-PPC-2R).
- b. Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).
- c. Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).
- d. Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).
- e. Detoxification.
- f. PMIC substance abuse treatment services.
- g. Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.
- h. Ambulance services for substance abuse conditions.
- i. Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- j. Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

88.65(5) Covered diagnoses. Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no diagnosis pursuant to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.
2. Substance abuse: 303-305.9.

88.65(6) Excluded services. Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

88.65(7) Iowa wellness plan service benefits. Services described in 441—Chapter 74 that otherwise constitute covered services pursuant to this rule shall be included in Iowa Plan services for members enrolled in the Iowa Plan who are also Iowa wellness plan members.

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441—88.66(249A) Emergency services.

88.66(1) Availability of services. The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

88.66(2) Payment for emergency room services. Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

a. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

(1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.

(2) Require authorization of any services beyond those provided in the emergency room.

b. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

88.66(3) Contractor payment liability. The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

88.66(4) Notification and claim filing time spans. The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

441—88.67(249A) Access to service.

88.67(1) Choice of provider. Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

88.67(2) Open panel requirement. The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

88.67(3) Requirements for participating provider panel. The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

a. Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where capability of participating providers to serve specific mental health and substance abuse needs does not exist.

b. Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

88.67(4) Adequate appointment system. The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

a. Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

b. Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

c. Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

88.67(5) Adequate after-hours call-in coverage. The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

88.67(6) Adequate referral system. The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

88.67(7) Discharge planning. The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

88.67(8) Lack of discharge plan. When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

(1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;

(2) A court order is required to allow placement of the child into the appropriate living arrangement;

(3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or

(4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8) "a."

441—88.68(249A) Review of contractor decisions and actions.

88.68(1) Clinical decision review. The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

- a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.
- b. Allow for participation by the enrollee and the provider.
- c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.
- d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.
- e. Ensure the participation of contractor staff with authority to require corrective action.
- f. Include at least one level of internal review.
- g. Ensure the confidentiality of the enrollee.

88.68(2) *Appeal to department.* Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

88.68(3) *Review of nonclinical decisions.* The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

- a. Allow initiation both verbally and in writing.
- b. Require a review conducted by someone other than the person who made the original decision.
- c. Require written notice acknowledging the receipt of a complaint or grievance.
- d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

88.68(4) *Written record.* All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

88.68(5) *Information concerning procedures relating to the review of contractor decisions and actions.* The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

88.68(6) *Periodic reports to the department.* The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

88.68(7) *Consent for state fair hearing.* Network providers which are contracted and in good standing with the Iowa plan contractor may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member. The network provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the network provider submits a document providing such member's approval of the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

[ARC 0583C, IAB 2/6/13, effective 4/1/13]

441—88.69(249A) Records and reports.

88.69(1) *Records system.* The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the contractor including follow-up of the implementation of discharge plans and referral to other providers.
- e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

88.69(2) *Content of individual treatment record.* The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

88.69(3) *Confidentiality of mental health information.* The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

88.69(4) *Confidentiality of substance abuse information.* The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

88.69(5) *Reports to the department.* The contractor shall submit reports to the department as follows:

- a. Encounter data on a monthly basis.
- b. Annual audited financial statements no later than 180 days after the close of each contract year.
- c. Periodic financial, utilization, and statistical reports as required by the department in the contract.

- d. Other reporting requirements as specified in the contract.

88.69(6) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.70(249A) Marketing. The marketing of Iowa Plan services is prohibited.

441—88.71(249A) Enrollee education.

88.71(1) *Use of services.* The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; statement of consumer rights and responsibilities; out-of-area use of service; availability

of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

88.71(2) *Outreach to members with special needs.* The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

88.71(3) *Patient rights and responsibilities.* The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

441—88.72(249A) Payment to the contractor.

88.72(1) *Capitation rate.* In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

88.72(2) *Determination of rate.* The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

88.72(3) *Payment for services to other recipients.* When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

88.72(4) *Third-party liability.* If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

441—88.73(249A) Claims payment.

88.73(1) *Claims payment by contractor.* The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

a. For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.

b. For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.

c. For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

88.73(2) *Limits on payment responsibility for services.*

a. The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.

b. The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.

c. The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.

d. The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.

e. Payment responsibilities for emergency room services are as provided at subrule 88.66(2).

f. Payment responsibility for services provided under the “keep kids safe” policy is set forth at subrule 88.67(8).

88.73(3) *Payment to nonparticipating providers.* In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

88.73(4) *Payment of crossover and copayments.* Rescinded IAB 1/9/02, effective 3/1/02.

441—88.74(249A) *Quality assurance.* The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

441—88.75(249A) *Iowa Plan advisory committee.* The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

441—88.76 to 88.80 Reserved.

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

441—88.81(249A) *Scope and definitions.*

88.81(1) *Purpose.* A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

- a. Enhance the quality of life and autonomy of frail older adults.
- b. Maximize the dignity of and respect for frail older adults.
- c. Enable frail older adults to live in the community as long as medically and socially feasible.
- d. Preserve and support frail older adults' family units.

88.81(2) *Scope.* PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

88.81(3) *Authorization.* A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

88.81(4) *Definitions.* For purposes of this division:

“Alternate PACE service site” means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

“Capitation rate” means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

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

“Contract year” means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

“Department” means the Iowa department of human services.

“Enrollee” means a person who is enrolled in a PACE program.

“Federal PACE regulations” means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

“*Interdisciplinary team*” means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

“*Medicaid enrollee*” means a Medicaid member who is enrolled in a PACE program.

“*Medicare beneficiary*” means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

“*Medicare enrollee*” means a Medicare beneficiary who is enrolled in a PACE program.

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

“*PACE center*” means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. “Primary care” shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

“*PACE enrollment agreement*” means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

“*PACE organization*” means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

“*PACE program*” means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

“*PACE program agreement*” means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

“*Service area*” means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

“*Services*” means both items and services provided to an enrollee by the PACE organization.

“*Trial period*” means the first three contract years in which a PACE organization operates under a PACE program agreement.

441—88.82(249A) PACE organization application and waiver process. This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

88.82(1) Application requirements. A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp.

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(2) Waiver of federal requirements. A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(3) *Review of applications and requests for waiver of federal requirements.* The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

88.82(4) *Department action on applications.* Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

441—88.83(249A) PACE program agreement. An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

88.83(1) *Content and terms of agreement.*

a. Required content. A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

b. Optional content. An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)"a"(5).

(2) Contain any additional terms and conditions agreed to by the parties.

88.83(2) *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

88.83(3) Enforcement of agreement. If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

- a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.
- b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.
- c. Terminate the PACE program agreement.

88.83(4) Termination of agreement by the department.

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph “c” of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department’s determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph “b” of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

88.83(5) Termination of agreement by PACE organization. A PACE organization may terminate an agreement after timely notice issued as follows:

a. To CMS and the department, 90 days before termination.

b. To enrollees, 60 days before termination.

88.83(6) Transitional care during termination. A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee’s medical records available to new providers.

441—88.84(249A) Enrollment and disenrollment. A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

88.84(1) Eligibility for Medicaid enrollees. To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The person must be eligible for Medicaid pursuant to the provisions in 441—Chapter 75 for persons in a medical institution.

(4) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(5) The department must determine that the person needs the nursing facility level of care.

(6) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

b. Other eligibility requirements.

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.84(4).

88.84(2) *Effective date of enrollment.* A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

88.84(3) *Duration of enrollment.* Enrollment continues until the enrollee's death unless either of the following actions occurs:

a. The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

b. The enrollee is involuntarily disenrolled, as described in subrule 88.84(5).

88.84(4) *Annual recertification.*

a. At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

b. Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

88.84(5) *Involuntary disenrollment.* An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

a. Reasons for involuntary disenrollment. An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(5) "b."

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.84(4) "b."

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

b. Disruptive or threatening behavior. “Disruptive or threatening behavior” refers to either of the following:

- (1) Behavior that jeopardizes the enrollee’s health or safety or the safety of others; or
- (2) Consistent refusal by the enrollee to comply with the enrollee’s individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

c. Documentation of disruptive or threatening behavior. If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee’s medical record:

- (1) The reasons for proposing to disenroll the enrollee.
- (2) All efforts to remedy the situation.

d. Noncompliant behavior. A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee’s behavior jeopardizes the enrollee’s health or safety or the safety of others. “Noncompliant behavior” includes repeated noncompliance with medical advice and repeated failure to keep appointments.

88.84(6) Effective date of disenrollment.

a. In disenrolling a Medicaid enrollee, the PACE organization must:

- (1) Use the most expedient process allowed under the PACE program agreement;
- (2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and
- (3) Give reasonable advance notice to the enrollee.

b. Until the date when enrollment is terminated, the following requirements must be met:

- (1) The PACE organization must continue to furnish all needed services.
- (2) The enrollee must continue to use PACE organization services.

88.84(7) Documentation of disenrollment. A PACE organization must meet the following requirements:

- a.* Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.
- b.* Make documentation available for review by CMS and the department.
- c.* Use the information on voluntary disenrollments in the PACE organization’s internal quality assessment and performance improvement program.

88.84(8) Reinstatement in other Medicare and medicaid programs. After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee’s reinstatement in other Medicare and Medicaid programs by:

- a.* Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and
- b.* Ensuring that medical records are made available to new providers in a timely manner.

88.84(9) Reinstatement in PACE. A previously disenrolled enrollee may be reinstated in a PACE program.

[ARC 0758C, IAB 5/29/13, effective 8/1/13]

441—88.85(249A) Program services. A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

88.85(1) Required services. The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

- a.* All Medicare-covered items and services.
- b.* All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.
- c.* Other services determined necessary by the enrollee’s interdisciplinary team to improve or maintain the enrollee’s overall health status.

88.85(2) Excluded services. The following services are excluded from coverage under PACE:

a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

b. In an inpatient facility:

(1) A private room and private-duty nursing services unless medically necessary; and

(2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

88.85(3) Service delivery. The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

(1) The PACE center,

(2) The enrollee's home, and

(3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

88.85(4) Minimum services furnished at a PACE center. At a minimum, the following services must be furnished at each primary or alternate PACE center:

a. Primary care, including physician and nursing services.

b. Social services.

c. Restorative therapies, including physical therapy and occupational therapy.

d. Personal care and supportive services.

e. Nutritional counseling.

f. Recreational therapy.

g. Meals.

88.85(5) Primary care. Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

a. Managing an enrollee's medical situations; and

b. Overseeing an enrollee's use of medical specialists and inpatient care.

88.85(6) Out-of-network emergency care. A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

a. *Definitions.* As used in this subrule, the following definitions apply:

"*Emergency medical condition*" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Serious jeopardy to the health of the enrollee.
2. Serious impairment to bodily functions of the enrollee.
3. Serious dysfunction of any bodily organ or part of the enrollee.

“Emergency services” means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization’s service area.

“Poststabilization care” means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

“Urgent care” means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee’s life or functioning is not in severe jeopardy.

b. Plan. A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.
2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

c. Explanation to enrollee. The organization must ensure that the enrollee or caregiver, or both, understand:

- (1) When and how to access out-of-network emergency services, and
- (2) That no prior authorization is needed.

441—88.86(249A) Access to PACE services. An enrollee’s access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee’s health and social status.

88.86(1) Interdisciplinary team. A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

a. Team composition. The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master’s-level social worker.
- (4) Physical therapist.
- (5) Occupational therapist.
- (6) Recreational therapist or activity coordinator.
- (7) Dietitian.
- (8) PACE center manager.
- (9) Home care coordinator.
- (10) Personal care attendant or attendant’s representative.
- (11) Driver or driver’s representative.

b. Team responsibilities. Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial

assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.

(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.

(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

c. Exchange of information. The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

88.86(2) Initial assessment. The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

a. Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) Home care coordinator.

b. At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

c. The assessment of each enrollee must include, but not be limited to, assessment of the following:

(1) Physical and cognitive function and ability.

(2) Medication use.

(3) Enrollee and caregiver preferences for care.

(4) Socialization and availability of family support.

(5) Current health status and treatment needs.

(6) Nutritional status.

(7) Home environment, including home access and egress.

(8) Enrollee behavior.

(9) Psychosocial status.

(10) Medical and dental status.

(11) Enrollee language.

88.86(3) Plan of care. The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

a. Development. The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

b. Content. The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

c. Documentation. The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

d. Implementation. The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and

(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

e. Evaluation. On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

88.86(4) Reassessment.

a. Semiannual reassessment. On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Recreational therapist or activity coordinator.

(5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

b. Annual reassessment. On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

(1) Physical therapist.

(2) Occupational therapist.

(3) Dietitian.

(4) Home care coordinator.

c. Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2) "a" must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

d. Changes to plan of care. Interdisciplinary team members who conduct a reassessment must:

(1) Reevaluate the enrollee's plan of care.

(2) Discuss any changes in the plan of care with the interdisciplinary team.

(3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.

(4) Document all assessment and reassessment information in the enrollee's medical record.

(5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

88.86(5) Procedures for resolving enrollee request to change the plan of care. The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

a. Except as provided in paragraph "b" of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

b. The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

- (1) The enrollee or designated representative requests the extension; or
- (2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

c. The PACE organization must:

- (1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and
- (2) Provide the specific reasons for the denial in understandable language.

d. The PACE organization is responsible for:

- (1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.
- (2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.
- (3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

e. If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

f. The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

441—88.87(249A) Program administrative requirements. A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

88.87(1) Enrollee rights. A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

88.87(2) Data collection, record maintenance, and reporting. A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

88.87(3) Quality assessment and performance improvement. A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

88.87(4) Federal and state monitoring.

a. The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

- (1) Corrective action required pursuant to 42 CFR Section 460.194; and
- (2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

b. The PACE program is subject to sanctions or termination pursuant to subrules 88.83(3) and 88.83(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division V.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.

441—88.88(249A) Payment.

88.88(1) *Medicaid payment to PACE organization.* Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

88.88(2) *Liability of Medicaid enrollee.* A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

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

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[◇] Two or more ARCs

¹ Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

CHAPTER 58

NURSING FACILITIES

[Prior to 7/15/87, Health Department[470] Ch 58]

481—58.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicates those standards are mandatory. The use of the words “should” and “could” indicates those standards are recommended.

“*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

“*Administrator*” means a person licensed pursuant to Iowa Code chapter 147 who administers, manages, supervises, and is in general administrative charge of a nursing facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“*Ambulatory*” means the condition of a person who immediately and without aid of another is physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

“*Board*” means the regular provision of meals.

“*Chairfast*” means capable of maintaining a sitting position but lacking the capacity of bearing own weight, even with the aid of a mechanical device or another individual.

“*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

“*Department*” means the state department of inspections and appeals.

“*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

“*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

“*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Nourishing snack*” is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the “nourishing snack” will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility.

“*Person directed care environment*” means the provision of care and services provided in a facility that promotes decision making and choices by the resident, enhances the primary caregiver’s capacity to respond to each resident’s needs, and promotes a homelike environment. Examples of a person directed care environment include, but are not limited to, the Green House concept, the Eden alternative, service houses and neighborhoods.

“*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are assistance in getting in and out of bed, assistance with personal hygiene and bathing, assistance with dressing, meal assistance, and supervision over medications which can be self-administered.

“*Potentially hazardous food*” means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of clostridium botulinum, or in raw shell eggs, the growth of salmonella enteritidis. Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw seed sprouts; cut melons; and garlic and oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth of bacteria.

“*Primary care provider*” means any of the following who provide primary care and meet certification standards:

1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician assistant.

“Program of care” means all services being provided for a resident in a health care facility.

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

“Qualified nurse” means a registered nurse or a licensed practical nurse, as defined in Iowa Code chapter 152.

“Rate” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

“Responsible party” means the person who signs or cosigns the admission agreement required in 481—58.13(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

“Restraints” means any chemical, manual method or physical or mechanical device, material, or equipment attached to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

“Substantial evening meal” is defined as an offering of three or more menu items at one time, one of which includes a high protein such as meat, fish, eggs or cheese. The meal would represent no less than 20 percent of the day’s total nutritional requirements.

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 1752C, IAB 12/10/14, effective 1/14/15]

481—58.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual nursing facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

58.2(1) To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

58.2(2) Upon receipt of a request for variance, the director of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

58.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—58.3(135C) Application for licensure.

58.3(1) Initial application and licensing. In order to obtain an initial nursing facility license, for a nursing facility which is currently licensed, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Applicable exceptions found in rule 481—61.2(135C) shall apply based on the construction date of the facility.

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

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

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Meet the requirements of a nursing facility for which licensure application is made;

h. Comply with all other local statutes and ordinances in existence at the time of licensure;

i. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(2) In order to obtain an initial nursing facility license for a facility not currently licensed as a nursing facility, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Exceptions noted in 481—subrule 61.1(2) shall not apply;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

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

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(3) *Renewal application.* In order to obtain a renewal of the nursing facility license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of nursing facility license;

b. Submit the statutory license fee for a nursing facility with the application for renewal;

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

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

58.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

481—58.4(135C) General requirements.

58.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

58.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

58.4(3) The posted license shall accurately reflect the current status of the nursing facility. (III)

58.4(4) Licenses expire one year after the date of issuance or as indicated on the license.

58.4(5) No nursing facility shall be licensed for more beds than have been approved by the health facilities construction review committee.

58.4(6) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—58.5(135C) Notifications required by the department. The department shall be notified:

58.5(1) Within 48 hours, by letter, of any reduction or loss of nursing or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

58.5(2) Of any proposed change in the nursing facility's functional operation or addition or deletion of required services; (III)

58.5(3) Thirty days before addition, alteration, or new construction is begun in the nursing facility or on the premises; (III)

58.5(4) Thirty days in advance of closure of the nursing facility; (III)

58.5(5) Within two weeks of any change in administrator; (III)

58.5(6) When any change in the category of license is sought; (III)

58.5(7) Prior to the purchase, transfer, assignment, or lease of a nursing facility, the licensee shall:

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

58.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a nursing facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—58.6(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—58.7(135C) Licenses for distinct parts.

58.7(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

58.7(2) The following requirements shall be met for a separate licensing of a distinct part:

- a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)
- b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;
- c. A distinct part must be operationally and financially feasible;
- d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)
- e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

481—58.8(135C) Administrator.

58.8(1) Each nursing facility shall have one person in charge, duly licensed as a nursing home administrator or acting in a provisional capacity. (III)

58.8(2) A licensed administrator may act as an administrator for not more than two nursing facilities.

- a. The distance between the two facilities shall be no greater than 50 miles. (II)
- b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)
- c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

58.8(3) The licensee may be the licensed nursing home administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

58.8(4) A provisional administrator may be appointed on a temporary basis by the nursing facility licensee to assume the administrative duties when the facility, through no fault of its own, has lost its administrator and has been unable to replace the administrator.

- a. No facility licensed under Iowa Code chapter 135C shall be permitted to have a provisional administrator for more than 12 consecutive months.
- b. The facility shall notify the department in writing within ten business days of the administrator's appointment. The written notice shall include the estimated time frame for the appointment of the provisional administrator and the reason for the appointment of a provisional administrator. (III)
- c. The provisional administrator's appointment must be approved by the board of examiners for nursing home administrators. The approval shall be confirmed in writing to the department. (III)

58.8(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. The administrator shall not be absent from the facility for more than 3 months without approval of the department. (III)

The person designated shall:

- a. Be knowledgeable of the operation of the facility; (III)
- b. Have access to records concerned with the operation of the facility; (III)
- c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)
- d. Be at least 21 years of age; (III)
- e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)
- f. Have had training to carry out assignments and take care of emergencies and sudden illness of residents. (III)

58.8(6) A licensed administrator in charge of two facilities shall employ an individual designated as a full-time assistant administrator for each facility. (III)

58.8(7) An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

[ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2020C, IAB 6/10/15, effective 7/15/15]

481—58.9(135C) Administration.

58.9(1) The licensee shall:

- a. Assume the responsibility for the overall operation of the nursing facility; (III)
- b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)
- c. Establish written policies, which shall be available for review, for the operation of the nursing facility. (III)

58.9(2) The administrator shall:

- a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)
- b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)
- c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)
- d. Make available the nursing facility payroll records for departmental review as needed; (III)

e. Be required to maintain a staffing pattern of all departments. These records must be maintained for six months and are to be made available for departmental review. (III)

481—58.10(135C) General policies.

58.10(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

58.10(2) There shall be a written job description developed for each category of worker. The job description shall include title of job, job summary, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

58.10(4) Health certificates for all employees shall be available for review. (III)

58.10(5) Rescinded IAB 10/19/88, effective 11/23/88.

58.10(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

58.10(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

58.10(8) Infection control program. Each facility shall have a written and implemented infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at <http://www.cdc.gov/ncidod/dhqp/index.html>.

58.10(9) Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

58.10(10) There shall be written policies for resident care programs and services as outlined in these rules. (III)

58.10(11) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—58.11(135C) Personnel.

58.11(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a nursing facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a nursing facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

- (1) Which is transmissible through required workplace contact, (I, II, III)
- (2) Which presents a significant risk of infecting others, (I, II, III)
- (3) Which presents a substantial possibility of harming others, and (I, II, III)
- (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

f. Persons employed in all departments, except the nursing department of a nursing facility shall be qualified through formal training or through prior experience to perform the type of work for which they have been employed. Prior experience means at least 240 hours of full-time employment in a field related to their duties. Persons may be hired in laundry, housekeeping, activities and dietary without experience or training if the facility institutes a formal in-service training program to fit the job description in question and documents such as having taken place within 30 days after the initial hiring of such untrained employees. (III)

g. Rescinded, effective 7/14/82.

h. The health services supervisor shall be a qualified nurse as defined in these regulations. (II)

i. Those persons employed as nurse's aides, orderlies, or attendants in a nursing facility who have not completed the state-approved 75-hour nurse's aide program shall be required to participate in a structured on-the-job training program of 20 hours' duration to be conducted prior to any resident contact, except that contact required by the training program. This educational program shall be in addition to facility orientation. Each individual shall demonstrate competencies covered by the curriculum. This shall be observed and documented by an R.N. and maintained in the personnel file. No aide shall work independently until this is accomplished, nor shall the aide's hours count toward meeting the minimum hours of nursing care required by the department. The curriculum shall be approved by the department. An aide who has completed the state-approved 75-hour course may model skills to be learned.

Further, such personnel shall be enrolled in a state-approved 75-hour nurse's aide program to be completed no later than six months from the date of employment. If the state-approved 75-hour program has been completed prior to employment, the on-the-job training program requirement is waived. The 20-hour course is in addition to the 75-hour course and is not a substitute in whole or in part. The 75-hour program, approved by the department, may be provided by the facility or academic institution.

Newly hired aides who have completed the state-approved 75-hour course shall demonstrate competencies taught in the 20-hour course upon hire. This shall be observed and documented by an R.N. and maintained in the personnel file.

All personnel administering medications must have completed the state-approved training program in medication administration. (II)

j. There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments. (II, III)

k. Nurse aides, orderlies or attendants in a nursing facility who have received training other than the Iowa state-approved program, must pass a challenge examination approved by the department of inspections and appeals. Evidence of prior formal training in a nursing aide, orderly, attendant, or other comparable program must be presented to the facility or institution conducting the challenge examination before the examination is given. The approved facility or institution, following department of inspections and appeals guidelines, shall make the determination of who is qualified to take the examination. Documentation of the challenge examinations administered shall be maintained.

58.11(2) *Nursing supervision and staffing.*

a. Rescinded IAB 8/7/91, effective 7/19/91.

b. Where only part-time nurses are employed, one nurse shall be designated health service supervisor. (III)

c. A qualified nurse shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences or emergencies. Pertinent information for contacting such relief person shall be posted at the nurse's station. (III)

d. When the health service supervisor serves as the administrator of a facility 50 beds and over, a qualified nurse must be employed to relieve the health service supervisor of nursing responsibilities. (III)

e. The department may establish on an individual facility basis the numbers and qualifications of the staff required in the facility using as its criteria the services being offered and the needs of the residents. (III)

f. Additional staffing, above the minimum ratio, may be required by the department commensurate with the needs of the individual residents. (III)

g. The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours per resident day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours per resident per day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. (II, III)

h. The health service supervisor's hours worked per week shall be included in computing the 20 percent requirement.

i. A nursing facility of 75 beds or more shall have a qualified nurse on duty 24 hours per day, seven days a week. (II, III)

j. In facilities under 75 beds, if the health service supervisor is a licensed practical nurse, the facility shall employ a registered nurse, for at least four hours each week for consultation, who must be on duty at the same time as the health service supervisor. (II, III)

(1) This shall be an on-site consultation and documentation shall be made of the visit. (III)

(2) The registered nurse-consultant shall have responsibilities clearly outlined in a written agreement with the facility. (III)

(3) Consultation shall include but not be limited to the following: counseling the health service supervisor in the management of the health services; (III) reviewing and evaluating the health services in determining that the needs of the residents are met; (II, III) conducting a review of medications at least monthly if the facility does not employ a registered nurse part-time. (II, III)

k. Facilities with 75 or more beds must employ a health service supervisor who is a registered nurse. (II)

l. There shall be at least two people who shall be capable of rendering nursing service, awake, dressed, and on duty at all times. (II)

m. Physician's orders shall be implemented by qualified personnel. (II, III)

58.11(3) *Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.* The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

[ARC 0903C, IAB 8/7/13, effective 9/11/13]

481—58.12(135C) Admission, transfer, and discharge.

58.12(1) *General admission policies.*

a. No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide. (II, III)

b. No nursing facility shall admit more residents than the number of beds for which it is licensed, except guest rooms for visitors. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a nursing facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

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

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

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the nursing facility belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

l. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II, III)

58.12(2) Discharge or transfer:

a. Prior notification shall be made to the resident, as well as the resident's next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the nursing facility for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such a discharge or transfer. (II, III)

d. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 58.15(2) "k" of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—58.13(135C) Contracts. Each contract shall:

58.13(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

58.13(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. Furthermore, the contract shall: (III)

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in 58.13(3); (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

58.13(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the nursing assessment at the time of admission, which is determined in consultation with the administrator; (III)

58.13(4) Include the total fee to be charged initially to the specific resident; (III)

58.13(5) State the conditions whereby the facility may make adjustments to the facility's overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

b. Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

58.13(6) State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

58.13(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

a. The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

58.13(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

58.13(9) State the conditions of voluntary discharge or transfer; (III)

58.13(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

58.13(11) Each party shall receive a copy of the signed contract. (III)

481—58.14(135C) Medical services.

58.14(1) Each resident in a nursing facility shall designate a licensed physician who may be called when needed. Professional management of a resident's care shall be the responsibility of the hospice program when:

a. The resident is terminally ill, and

b. The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

c. The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

58.14(2) Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

58.14(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

58.14(4) Rescinded, effective 7/14/82.

58.14(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

58.14(6) A schedule listing the names and telephone numbers of the physicians shall be posted in each nursing station. (III)

58.14(7) Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

58.14(8) Physician delegation of tasks. Each resident, including private pay residents, shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured from the date of admission and is not to include preadmission physicals.

a. For a skilled nursing patient, the resident must be seen by a physician for the initial comprehensive visit. Additional visits are required at least once every 30 days for 90 days after admission and at least once every 60 days thereafter. After the initial comprehensive visit, alternate required visits may be performed by an advanced registered nurse practitioner, clinical nurse specialist or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

b. Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

c. In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician assistant must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the physician. (III)

d. Nurse practitioners, clinical nurse specialists, and physician assistants may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status. (III)

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law*

	Initial Comprehensive Visit/Orders	Other Required Visits ¹	Other Medically Necessary Visits and Orders ²	Certification/Recertification
Skilled Nursing Facilities				
Physician assistant, nurse practitioner and clinical nurse specialist employed by the facility	May not perform/May not sign	May perform alternate visits	May perform and sign	May not sign
Physician assistant, nurse practitioner and clinical nurse specialist not a facility employee	May not perform/May not sign	May perform alternate visits	May perform and sign	May sign subject to state requirements

	Initial Comprehensive Visit/Orders	Other Required Visits ¹	Other Medically Necessary Visits and Orders ²	Certification/Recertification
Nursing Facilities				
Nurse practitioner, clinical nurse specialist, and physician assistant employed by the facility	May not perform/May not sign	May not perform	May perform and sign	Not applicable ⁺
Nurse practitioner, clinical nurse specialist, and physician assistant not a facility employee	May perform/May sign	May perform	May perform and sign	Not applicable ⁺

*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician assistants.

¹ Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician assistants after the initial comprehensive visit is completed.

² Medically necessary visits may be performed prior to the initial comprehensive visit.

⁺ This requirement relates specifically to coverage of Part A Medicare stays, which can take place only in a Medicare-certified skilled nursing facility.

[ARC 1048C, IAB 10/2/13, effective 11/6/13; ARC 1398C, IAB 4/2/14, effective 5/7/14]

481—58.15(135C) Records.

58.15(1) *Resident admission record.* The licensee shall keep a permanent record on all residents admitted to a nursing facility with all entries current, dated, and signed. This shall be a part of the resident clinical record. (III) The admission record form shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address. (III)

58.15(2) *Resident clinical record.* There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

- a. Admission record; (III)
- b. Admission diagnosis; (III)
- c. Physical examination: The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints, estimation of restoration potential and results of any diagnostic procedures. The report of the physical examination shall be signed by the physician. (III)
- d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)
- e. Physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly; (III)
- f. Progress notes.
 - (1) Physician shall enter a progress note at the time of each visit; (III)

(2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)

g. All laboratory, X-ray, and other diagnostic reports; (III)

h. Nurse's record including:

(1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)

(2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)

(3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)

(4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)

i. Medication record.

(1) An accurate record of all medications administered shall be maintained for each resident. (II, III)

(2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)

j. Death record. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

k. Transfer form.

(1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)

(2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)

(3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)

l. Consultation reports shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, ophthalmologists, and others. (III)

58.15(3) Resident personal record. Personal records may be kept as a separate file by the facility.

a. Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.

b. Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)

c. When the resident's records are closed, the information shall become a part of the final record. (III)

d. Personal records shall include a duplicate copy of the contract(s). (III)

58.15(4) Incident record.

a. Each nursing facility shall maintain an incident record report and shall have available incident report forms. (III)

b. Report of incidents shall be in detail on a printed incident report form. (III)

c. The person in charge at the time of the incident shall prepare and sign the report. (III)

d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)

e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)

f. A copy of the incident report shall be kept on file in the facility. (III)

58.15(5) Retention of records.

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

58.15(6) Reports to the department. The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

58.15(7) Personnel record.

- a. An employment record shall be kept for each employee, consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, criminal history and dependent adult abuse background checks, and date and reason for discharge or resignation. (III)
- b. The personnel records shall be made available for review upon request by the department. (III)

481—58.16(135C) Resident care and personal services.

58.16(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

58.16(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

58.16(3) Residents shall have clean clothing as needed to present a neat appearance, to be free of odors, and to be comfortable. Clothing shall be based on resident choice and shall be appropriate to residents' activities and to the weather. (III)

58.16(4) Rescinded, effective 7/14/82.

58.16(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

58.16(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

58.16(7) Rescinded, effective 7/14/82.

58.16(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

58.16(9) Except for those who request differently, residents who are not bedfast shall be fully dressed each day to maintain self-esteem and promote the residents' normal lifestyles. (III)

58.16(10) Residents shall receive a bath of their choice, based on the facility's accommodations, as needed to maintain proper hygiene. (II, III)

481—58.17 Rescinded, effective 7/14/82.

481—58.18(135C) Nursing care.

58.18(1) Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

58.18(2) Rescinded IAB 4/2/14, effective 5/7/14.

58.18(3) The facility shall provide resident and family education as an integral part of restorative and supportive care. (III)

58.18(4) The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II, III) (Prompt response being considered as no longer than 15 minutes.)

[ARC 1398C, IAB 4/2/14, effective 5/7/14]

481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

58.19(1) Activities of daily living.

- a. Bathing; (II, III)
- b. Daily oral hygiene (denture care); (II, III)
- c. Routine shampoo; (II, III)
- d. Nail care; (III)
- e. Shaving; (III)
- f. Daily care and application of prostheses (glasses, hearing aids, glass eyes, limb prosthetics, braces, or other assistive devices); (II, III)
 - g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)
 - h. Daily routine range of motion; (II, III)
 - i. Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)
 - j. Elimination.
 - (1) Assistance to and from the bathroom and perineal care; (II, III)
 - (2) Bedpan assistance; (II, III)
 - (3) Care for incontinent residents; (II, III)
 - (4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III)
 - k. Colostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
 - l. Ileostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
 - m. All linens necessary; (III)
 - n. Nutrition and meal service.
 - (1) Regular, therapeutic, modified diets, and snacks; (I, II, III)
 - (2) Mealtime preparation of resident; (II, III)
 - (3) Assistance to and from meals; (II, III)
 - (4) In-room meal service or tray service; (II, III)
 - (5) Assistance with food preparation and meal assistance including total assistance if needed; (II, III)
 - (6) Assistance with adaptive devices; (II, III)
 - (7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)
 - o. Promote initiation of self-care for elements of resident care; (II, III)
 - p. Oral suctioning (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse). (I, II)

58.19(2) Medication and treatment.

- a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)
- b. Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II)
- c. Blood glucose monitoring; (I, II)
- d. Vital signs, blood pressure, and weights; (I, II)
- e. Ambulation and transfer; (II, III)
- f. Provision of restraints; (I, II)
- g. Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)
- h. Provision of all treatments; (I, II, III)

- i.* Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III)
- j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)
[ARC 1398C, IAB 4/2/14, effective 5/7/14]

481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

- 58.20(1)** Direct the implementation of the physician's orders; (I, II)
- 58.20(2)** Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)
- 58.20(3)** Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)
- 58.20(4)** Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:
 - a.* The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)
 - b.* The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)
 - c.* The health care plan is readily available for use by all personnel caring for the resident; (III)
- 58.20(5)** Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable; (II, III)
- 58.20(6)** Supervise health services personnel to ensure they perform the following restorative measures in their daily care of residents:
 - a.* Maintaining good bodily alignment and proper positioning; (II, III)
 - b.* Making every effort to keep the resident active except when contraindicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities; (III)
 - c.* Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests as necessary; (III)
 - d.* Assisting residents to carry out prescribed therapy exercises between visits of the therapist; (III)
 - e.* Assisting residents with routine range of motion exercises; (III)
- 58.20(7)** Plan and conduct nursing staff orientation and in-service programs and provide for training of nurse's aides; (III)
- 58.20(8)** Plan with the resident and the resident's physician and family and health-related agencies for the care of the resident upon discharge; (III)
- 58.20(9)** Designate a responsible person to be in charge during absences; (III)
- 58.20(10)** Be responsible for all assignments and work schedules for all health services personnel to ensure that the health needs of the residents are met; (III)
- 58.20(11)** Ensure that all nurse's notes are descriptive of the care rendered including the resident's response; (III)
- 58.20(12)** Visit each resident routinely to be knowledgeable of the resident's current condition; (III)
- 58.20(13)** Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)
- 58.20(14)** Keep the administrator informed of the resident's status; (III)
- 58.20(15)** Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning; (III)

58.20(16) Supervise serving of meals to ensure that individuals unable to assist themselves are promptly fed and that special eating adaptive devices are available as needed; (II, III)

58.20(17) Make available a nursing procedure manual which shall include all procedures practiced in the facility; (III)

58.20(18) Participate with the administrator in the formulation of written policies and procedures for resident services; (III)

58.20(19) The person in charge shall immediately notify the family of any accident, injury, or adverse change in the resident's condition requiring physician's notification. (III)

481—58.21(135C) Drugs, storage, and handling.

58.21(1) Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

a. A cabinet with a lock, convenient to nursing service, shall be provided and used for storage of all drugs, solutions, and prescriptions; (III)

b. The drug storage cabinet shall be kept locked when not in use; (III)

c. The medication cabinet key shall be in the possession of the person directly responsible for issuing medications; (II, III)

d. Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

58.21(2) Drugs for external use shall be stored separately from drugs for internal use. (III)

58.21(3) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items. A method for locking these medications shall be provided. (III)

58.21(4) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

58.21(5) All flammable materials shall be specially stored and handled in accordance with applicable local and state fire regulations. (II)

58.21(6) A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

a. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

b. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

c. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

d. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

e. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph “*c*” of this subrule do not apply to this individual.

58.21(7) Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

58.21(8) An accurate written record of medications administered shall be made by the individual administering the medication. (III)

58.21(9) Records shall be kept of all Schedule II drug medications received and dispensed in accordance with the controlled drug and substance Act. (III)

58.21(10) Any unusual resident reaction shall be reported to the physician at once. (II)

58.21(11) A policy shall be established by the facility in conjunction with a licensed pharmacist to govern the distribution of prescribed medications to residents who are on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 58.21(14) “*a*,” non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident’s name, the facility, the medication, its strength, dose, and time of administration.

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

c. Medication distributed as above may be issued only by a nurse responsible for administering medication. (I, II, III)

58.21(12) Emergency medications. A nursing facility shall provide emergency medications pursuant to the following requirements: (III)

a. Prescription drugs as well as nonprescription items must be prescribed or approved by the physician, in consultation with the pharmacist, who provides emergency service to the facility; (III)

b. The emergency medications shall be stored in an accessible place; (III)

c. A list of the emergency medications and quantities of each item shall be maintained by the facility; (III)

d. The container holding the emergency medications shall be closed with a seal which may be broken when drugs are required in an emergency or for inspection; (III)

e. Any item removed from the emergency medications shall be replaced within 48 hours; (III)

f. A permanent record shall be kept of each time the emergency medications are used; (III)

g. The emergency medications shall be inspected by a pharmacist at least once every three months to determine the stability of items. (III)

58.21(13) Drug handling.

a. Bulk supplies of prescription drugs shall not be kept in a nursing facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

b. Inspection of drug storage condition shall be made by the health service supervisor and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the nurse and pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician’s order, and drugs improperly stored. (III)

c. If the facility permits licensed nurses to dilute or reconstitute drugs at the nursing station, distinctive supplementary labels shall be available for the purpose. The notation on the label shall be so made as to be indelible. (III)

d. Dilution and reconstitution of drugs and their labeling shall be done by the pharmacist whenever possible. If not possible, the following shall be carried out only by the licensed nurse:

(1) Specific directions for dilution or reconstitution and expiration date should accompany the drug; (III)

(2) A distinctive supplementary label shall be affixed to the drug container when diluted or reconstituted by the nurse for other than immediate use. (III) The label shall bear the following: resident's name, dosage and strength per unit/volume, nurse's name, expiration date, and date and time of dilution. (III)

58.21(14) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible or makeshift labels, or medication samples shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. There shall be no medications or any solution in unlabeled containers. (II, III)

d. The medications of each resident shall be kept or stored in the originally received containers. (II, III)

e. Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label of a drug container. (II, III)

f. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

g. Unused prescription drugs prescribed for residents who are deceased shall be returned to the supplying pharmacist. (III)

h. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

i. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

j. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

k. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible nurse with a witness and a notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

l. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The physician, in consultation with the pharmacist serving the home, shall institute policies and provide procedures for review and endorsement of stop orders on drugs. This policy shall be conveniently located for personnel administering medications. (II, III)

m. No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

n. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided. (II)

o. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

p. A qualified nurse shall:

(1) Establish a medication schedule system which identifies the time and dosage of each medication prescribed for each resident, is based on the resident's desired routine, and is approved by the resident's physician. (II, III)

(2) Establish a medication record containing the information specified above needed to monitor each resident's drug regimen. (II, III)

q. Telephone orders shall be taken by a qualified nurse. Orders shall be written into the resident's record and signed by the person receiving the order. Telephone orders shall be submitted to the physician for signature within 48 hours. (III)

r. A pharmacy operating in connection with a nursing facility shall comply with the provisions of the pharmacy law requiring registration of pharmacies and the regulations of the Iowa board of pharmacy examiners. (III)

s. In a nursing facility with a pharmacy or drug supply, service shall be under the personal supervision of a pharmacist licensed to practice in the state of Iowa. (III)

58.21(15) Drug administration.

a. Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician assistant (PA). In the case of a resident who has been certified by the resident's physician or physician assistant (PA) as capable of taking the resident's own insulin, the resident may inject the resident's own insulin. (II)

b. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)

[ARC 1050C, IAB 10/2/13, effective 11/6/13]

481—58.22(135C) Rehabilitative services. Rehabilitative services shall be provided to maintain function or improve the resident's ability to carry out the activities of daily living.

58.22(1) Physical therapy services.

a. Each facility shall have a written agreement with a licensed physical therapist to provide physical therapy services. (III)

b. Physical therapy shall be rendered only by a physical therapist licensed to practice in the state of Iowa. All personnel assisting with the physical therapy of residents must be under the direction of a licensed physical therapist. (II, III)

c. The licensed physical therapist shall:

(1) Evaluate the resident and prepare a physical therapy treatment plan conforming to the medical orders and goals; (III)

(2) Consult with other personnel in the facility who are providing resident care and plan with them for the integration of a physical therapy treatment program into the overall health care plan; (III)

(3) Instruct the nursing personnel responsible for administering selected restorative procedures between treatments; (III)

(4) Present programs in the facility's in-service education programs. (III)

d. Treatment records in the resident's medical chart shall include:

(1) The physician's prescription for treatment; (III)

(2) An initial evaluation note by the physical therapist; (III)

(3) The physical therapy care plan defining clearly the long-term and short-term goals and outlining the current treatment program; (III)

(4) Notes of the treatments given and changes in the resident's condition; (III)

(5) A complete discharge summary to include recommendations for nursing staff and family. (III)

e. There shall be adequate facilities, space, appropriate equipment, and storage areas as are essential to the treatment or examinations of residents. (III)

58.22(2) Other rehabilitative services.

a. The facility shall arrange for specialized and supportive rehabilitative services when such services are ordered by a physician. (III) These may include audiology and occupational therapy.

- b.* Audiology services shall be under the direction of a person licensed in the state of Iowa by the board of speech pathology and audiology. (II, III)
- c.* Occupational therapy services shall be under the direction of a qualified occupational therapist who is currently registered by the American Occupational Therapy Association. (II, III)
- d.* The appropriate professional shall:
 - (1) Develop the treatment plan and administer or direct treatment in accordance with the physician's prescription and rehabilitation goals; (III)
 - (2) Consult with other personnel within the facility who are providing resident care and plan with them for the integration of a treatment program into the overall health care plan. (III)

481—58.23(135C) Dental, diagnostic, and other services.**58.23(1) Dental services.**

- a.* The nursing facility personnel shall assist residents to obtain regular and emergency dental services. (III)
- b.* Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)
- c.* Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)
- d.* All dental reports or progress notes shall be included in the clinical record. (III)
- e.* Nursing personnel shall assist the resident in carrying out dentist's recommendations. (III)
- f.* Dentists shall be asked to participate in the in-service program of the facility. (III)

58.23(2) Diagnostic services.

- a.* The nursing facility shall make provisions for promptly securing required clinical laboratory, X-ray, and other diagnostic services. (III)
- b.* All diagnostic services shall be provided only on the written, signed order of a physician. (III)
- c.* Agreements shall be made with the local hospital laboratory or independent laboratory to perform specific diagnostic tests when they are required. (III)
- d.* Transportation arrangements for residents shall be made, when necessary, to and from the source of service. (III)
- e.* Copies of all diagnostic reports shall be requested by the facility and included in the resident's clinical record. (III)
- f.* The physician ordering the specific diagnostic service shall be promptly notified of the results. (III)
- g.* Simple tests such as customarily done by nursing personnel for diabetic residents may be performed in the facility. (III)

58.23(3) Other services.

- a.* The nursing facility shall assist residents to obtain such supportive services as requested by the physician. (III)
- b.* Transportation arrangements shall be made when necessary. (III)
- c.* Services could include the need for prosthetic devices, glasses, hearing aids, and other necessary items. (III)

481—58.24(135C) Dietary.

58.24(1) Organization of dietetic services. The facility shall meet the needs of the residents and provide the services listed in this standard. If the service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)

- a.* There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)
- b.* There shall be written job descriptions for each position in dietetic services. The job descriptions shall be made available for use by dietetic services. (III)

58.24(2) Dietary staffing.

- a.* The facility shall employ a qualified dietary supervisor who:
- (1) Is a qualified dietitian as defined in 58.24(2)“e”; or
 - (2) Is a graduate of a dietetic technician training program approved by the American Dietetic Association; or
 - (3) Is a certified dietary manager certified by the certifying board for dietary managers of the Dietary Managers Association (DMA) and maintains that credential through 45 hours of DMA-approved continuing education; or
 - (4) Has completed a DMA-approved course curriculum necessary to take the certification examination required to become a certified dietary manager; or
 - (5) Has documented evidence of at least two years’ satisfactory work experience in food service supervision and who is in an approved dietary manager association program and will successfully complete the program within 12 months of the date of enrollment; or
 - (6) Has completed or is in the final 90-hour training course approved by the department. (II, III)
- b.* The supervisor shall have overall supervisory responsibility for dietetic services and shall be employed for a sufficient number of hours to complete management responsibilities that include:
- (1) Participating in regular conferences with consultant dietitian, administrator and other department heads; (III)
 - (2) Writing menus with consultation from the dietitian and seeing that current menus are posted and followed and that menu changes are recorded; (III)
 - (3) Establishing and maintaining standards for food preparation and service; (II, III)
 - (4) Participating in selection, orientation, and in-service training of dietary personnel; (II, III)
 - (5) Supervising activities of dietary personnel; (II, III)
 - (6) Maintaining up-to-date records of residents identified by name, location and diet order; (III)
 - (7) Visiting residents to learn individual needs and communicating with other members of the health care team regarding nutritional needs of residents when necessary; (II, III)
 - (8) Keeping records of repairs of equipment in dietetic services. (III)
- c.* The facility shall employ sufficient supportive personnel to carry out the following functions:
- (1) Preparing and serving adequate amounts of food that are handled in a manner to be bacteriologically safe; (II, III)
 - (2) Washing and sanitizing dishes, pots, pans and equipment at temperatures required by procedures described elsewhere; (II, III)
 - (3) Serving of therapeutic diets as prescribed by the physician and following the planned menu. (II, III)
- d.* The facility may assign simultaneous duties in the kitchen and laundry, housekeeping, or nursing service to appropriately trained personnel. Proper sanitary and personal hygiene procedures shall be followed as outlined under the rules pertaining to staff hygiene. (II, III)
- e.* If the dietetic service supervisor is not a licensed dietitian, a consultant dietitian is required. The consultant dietitian shall be licensed by the state of Iowa pursuant to Iowa Code chapter 152A.
- f.* Consultants’ visits shall be scheduled to be of sufficient duration and at a time convenient to:
- (1) Record, in the resident’s medical record, any observations, assessments and information pertinent to medical nutrition therapy; (I, II, III)
 - (2) Work with residents and staff on resident care plans; (III)
 - (3) Consult with the administrator and others on developing and implementing policies and procedures; (III)
 - (4) Write or approve general and therapeutic menus; (III)
 - (5) Work with the dietetic supervisor on developing procedures, recipes and other management tools; (III)
 - (6) Present planned in-service training and staff development for food service employees and others. Documentation of consultation shall be available for review in the facility by the department. (III)

g. In facilities licensed for more than 15 beds, dietetic services shall be available for a minimum of a 12-hour span extending from the time of preparation of breakfast through supper. (III)

58.24(3) Nutrition and menu planning.

a. Menus shall be planned and followed to meet the nutritional needs of each resident in accordance with the physician's orders and in consideration of the resident's choices and preferences. (II, III)

b. Menus shall be planned to provide 100 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. A current copy of the Simplified Diet Manual published by Blackwell Publishing, Ames, Iowa, shall be available and used in the planning and serving of all meals. (II)

c. At least three meals or their equivalent shall be served daily, at regular hours comparable to normal mealtimes in the community. (II)

(1) There shall be no more than a 14-hour span between a substantial evening meal and breakfast except as provided in subparagraph (3) below. (II, III)

(2) The facility shall offer snacks at bedtime daily. (II, III)

(3) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast of the following day. The current resident group must agree to this meal span and a nourishing snack must be served. (II)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by department personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded. (III)

g. A file of tested recipes adjusted to the number of people to be served in the facility shall be maintained. (III)

h. Alternate foods shall be offered to residents who refuse the food served. (II, III)

58.24(4) Therapeutic diets.

a. Therapeutic diets shall be prescribed by the attending physician. A current therapeutic diet manual shall be readily available to attending physicians, nurses and dietetic service personnel. This manual shall be used as a guide for writing menus for therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and reviewing procedures for preparation and service of food. (III)

b. Personnel responsible for planning, preparing and serving therapeutic diets shall receive instructions on those diets. (III)

58.24(5) Food preparation and service.

a. Methods used to prepare foods shall be those which conserve nutritive value and flavor and meet the taste preferences of the residents. (III)

b. Foods shall be attractively served. (III)

c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (II, III)

d. Self-help devices shall be provided as needed. (II, III)

e. Table service shall be attractive. (III)

f. Plasticware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (III)

g. All food that is transported through public corridors shall be covered. (III)

h. All potentially hazardous food or beverages capable of supporting rapid and progressive growth of microorganisms that can cause food infections or food intoxication shall be maintained at temperatures of 41°F or below or at 140°F or above at all times, except during necessary periods of preparation. Frozen food shall be maintained frozen. (I, II, III)

i. Potentially hazardous food that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165°F for 15 seconds. (I, II, III)

j. Food must be reheated to 165°F within no more than two hours after the heating process begins. (I, II, III)

k. Cooked potentially hazardous food shall be cooled:

(1) Within two hours, from 140°F to 70°F; and

(2) Within four hours, from 70°F to 41°F or less. (I, II, III)

58.24(6) Dietary ordering, receiving, and storage.

a. All food and beverages shall be of wholesome quality and procured from sources approved or considered satisfactory by federal, state and local authorities. Food or beverages from unlabeled, rusty, leaking, broken or damaged containers shall not be served. (I, II, III)

b. A minimum of at least a one-week supply of staple foods and a three-day supply of perishable foods shall be maintained on the premises to meet the planned menu needs until the next food delivery. Supplies shall be appropriate to meet the requirements of the menu. (III)

c. All milk shall be pasteurized. (III)

d. Milk may be served in individual, single-use containers. Milk may be served from refrigerated bulk milk dispensers or from the original container. Milk served from a refrigerated bulk milk dispenser shall be dispensed directly into the glass or other container from which the resident drinks. (II, III)

e. Records which show amount and kind of food purchased shall be retained for three months and shall be made available to the department upon request. (III)

f. Dry or staple items shall be stored at least six inches (15 cm) above the floor in a ventilated room, not subject to sewage or wastewater backflow, and protected from condensation, leakage, rodents or vermin in accordance with the Food Code, 1999 edition. (III)

g. Pesticides, other toxic substances and drugs shall not be stored in the food preparation or storage areas used for food or food preparation equipment and utensils. Soaps, detergents, cleaning compounds or similar substances shall not be stored in food storage rooms or areas. (II)

h. Food storage areas shall be clean at all times. (III)

i. There shall be a reliable thermometer in each refrigerator, freezer and in storerooms used for food. (III)

j. Foods held in refrigerated or other storage areas shall be appropriately covered. Food that was prepared and not served shall be stored appropriately, clearly identifiable and dated. (III)

58.24(7) Sanitation in food preparation area.

a. Unless otherwise indicated in this chapter or 481—Chapter 61, the sanitary provisions as indicated in Chapters 3, 4 and 7 of the 1999 Food Code, U.S. Public Health Service, Food and Drug Administration, Washington, DC 20204, shall apply.

b. Residents may be allowed in the food preparation area. (III)

c. The food preparation area may be used as a dining area for residents, staff or food service personnel. (III)

d. All food service areas shall be kept clean, free from litter and rubbish, and protected from rodents, animals, roaches, flies and other insects. (II, III)

e. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair, and shall be free from breaks, corrosion, cracks and chipped areas. (II, III)

f. There shall be effective written procedures established for cleaning all work and serving areas. (III)

g. A schedule of cleaning duties to be performed daily shall be posted. (III)

h. An exhaust system and hood shall be clean, operational and maintained in good repair. (III)

i. Spillage and breakage shall be cleaned up immediately and disposed of in a sanitary manner. (III)

j. Wastes from the food service that are not disposed of by mechanical means shall be kept in leakproof, nonabsorbent, tightly closed containers when not in immediate use and shall be disposed of frequently. (III)

k. The food service area shall be located so it will not be used as a passageway by residents, guests or non-food service staff. (III)

l. The walls, ceilings and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. Walls and floors in wet areas should be moisture-resistant. (III)

m. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

n. There shall be no animals or birds in the food preparation area. (III)

o. All utensils used for eating, drinking, and preparing and serving food and drink shall be cleaned and disinfected or discarded after each use. (III)

p. If utensils are washed and rinsed in an automatic dishmachine, one of the following methods shall be used:

(1) When a conventional dishmachine is utilized, the utensils shall be washed in a minimum of 140°F using soap or detergent and sanitized in a hot water rinse of not less than 170°F. (II, III)

(2) When a chemical dishmachine is utilized, the utensils shall be washed in a minimum of 120°F using soap or detergent and sanitized using a chemical sanitizer that is automatically dispensed by the machine and is in a concentration equivalent to 50 parts per million (ppm) available chloride. (II, III)

q. If utensils are washed and rinsed in a three-compartment sink, the utensils shall be thoroughly washed in hot water at a minimum temperature of 110°F using soap or detergent, rinsed in hot water to remove soap or detergent, and sanitized by one of the following methods:

(1) Immersion for at least 30 seconds in clean water at 180°F; (II, III)

(2) Immersion in water containing bactericidal chemical at a minimum concentration as recommended by the manufacturer. (II, III)

r. After sanitation, the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used. (III)

s. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without first washing their hands. (III)

t. A mop and mop pail shall be provided for exclusive use in kitchen and food storage areas. (III)

58.24(8) Hygiene of food service personnel.

a. Personnel, if involved in dietetic services, shall be trained in basic food sanitation techniques, shall be clean and wear clean clothing, including a cap or a hairnet sufficient to contain, cover and restrain hair. Beards, mustaches and sideburns that are not closely cropped and neatly trimmed shall be covered. (III)

b. Personnel shall be excluded from duty when affected by skin infections or communicable diseases in accordance with the facility's infection control policies. (II, III)

c. Employee street clothing stored in the food service area shall be in a closed area. (III)

d. Food preparation sinks shall not be used for hand washing. Separate hand-washing facilities with soap, hot and cold running water, and single-use towels shall be used properly. (II, III)

e. The use of tobacco shall be prohibited in the food preparation area. (III)

58.24(9) Paid nutritional assistants. A paid nutritional assistant means an individual who meets the requirements of this subrule and who is an employee of the facility or an employee of a temporary employment agency employed by the facility. A facility may use an individual working in the facility as a paid nutritional assistant only if that individual has successfully completed a state-approved training program for paid nutritional assistants. (I, II, III)

a. *Training program requirements.*

(1) A state-approved training program for paid nutritional assistants must include, at a minimum, eight hours of training in the following areas:

1. Feeding techniques.
2. Assistance with feeding and hydration.
3. Communication and interpersonal skills.
4. Appropriate responses to resident behavior.

5. Safety and emergency procedures, including the Heimlich maneuver.
6. Infection control.
7. Resident rights.
8. Recognizing changes in residents that are inconsistent with their normal behavior and reporting these changes to the supervisory nurse.

(2) In addition to the training program requirements specified above, the training program must include at least four hours of classroom study, two hours of supervised laboratory work, and two hours of supervised clinical experience.

(3) A facility that offers a paid nutritional assistant training program must provide sufficient supplies in order to teach the objectives of the course.

(4) All paid nutritional assistant training program instructors shall be registered nurses. Other qualified health care professionals may assist the instructor in teaching the classroom portion and clinical or laboratory experiences. The ratio of students to instructor shall not exceed ten students per instructor in the clinical setting.

(5) Each individual enrolled in a paid nutritional assistant training program shall complete a 50-question multiple choice written test and must obtain a score of 80 percent or higher. In addition, the individual must successfully perform the feeding of a resident in a clinical setting. A registered nurse shall conduct the final competency determination.

(6) If an individual does not pass either the written test or competency demonstration, the individual may retest the failed portion a second time. If the individual does not pass either the written test or competency demonstration portion the second time, the individual shall not be allowed to retest.

b. Program approval. A facility or other entity may not offer or teach a paid nutritional assistant training program until the department has approved the program. Individuals trained in a program not approved by the department will not be allowed to function as paid nutritional assistants.

(1) A facility or other institution offering a paid nutritional assistant training program must provide the following information about the training program to the department before offering the program or teaching paid nutritional assistants:

1. Policies and procedures for program administration.
2. Qualifications of the instructors.
3. Maintenance of program records, including attendance records.
4. Criteria for determining competency.
5. Program costs and refund policies.
6. Lesson plans, including the objectives to be taught, skills demonstrations, assignments, quizzes, and classroom, laboratory and clinical hours.

(2) The facility or other institution offering a paid nutritional assistant training program must submit the materials specified above for department review. The department shall, within ten days of receipt of the material, advise the facility or institution whether the program is approved, or request additional information to assist the department in determining whether the curriculum meets the requirements for a paid nutritional assistant training program. Before approving any paid nutritional assistant training program, the department shall determine whether the curriculum meets the requirements specified in this subrule. The department shall maintain a list of facilities and institutions eligible to provide paid nutritional assistant training. (I, II, III)

(3) A facility shall maintain a record of all individuals who have successfully completed the required training program and are used by the facility as paid nutritional assistants. The individual shall complete the training program with a demonstration of knowledge and competency skills necessary to serve as a paid nutritional assistant. (I, II, III)

(4) Upon successful completion of the training program, the facility or other institution providing the training shall, within ten calendar days, provide the individual with a signed and dated certificate of completion. A facility that employs paid nutritional assistants shall maintain on file copies of the completed certificate and skills checklist for each individual who has successfully completed the training program. (I, II, III)

c. Working restrictions.

(1) A paid nutritional assistant must work under the supervision of a registered nurse or a licensed practical nurse. In an emergency, a paid nutritional assistant must call a supervisory nurse for help on the resident call system. (I, II, III)

(2) A facility must ensure that a paid nutritional assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube, parenteral or intravenous feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. (I, II, III)

481—58.25(135C) Social services program.

58.25(1) The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

58.25(2) The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

58.25(3) The social services plan, including specific goals and regular evaluation of progress, shall be incorporated into the overall plan of care. (III)

481—58.26(135C) Resident activities program.

58.26(1) *Organized activities.* Each nursing facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

e. The activity program shall include suitable activities for those residents unable to leave their rooms. (III)

f. The program shall be incorporated into the overall health plan and shall be designed to meet the goals as written in the plan.

58.26(2) *Coordination of activities program.*

a. Each nursing facility shall employ a person to direct the activities program. (III)

b. Staffing for the activity program shall be provided on the minimum basis of 35 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

58.26(3) *Duties of activity coordinator.* The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident's clinical record; (III)

(3) Monthly calendars, prepared in advance. (III)

- d. Coordinate the activity program with all other services in the facility; (III)
- e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

58.26(4) Supplies, equipment, and storage.

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

¹ Emergency, pursuant to Iowa Code section 17A.5(2)“b”(2).

² Objection filed 2/14/79; see Objection at end of chapter.

481—58.27(135C) Certified volunteer long-term care ombudsman program. A certified volunteer long-term care ombudsman appointed in accordance with Iowa Code section 231.45 as amended by 2013 Iowa Acts, Senate File 184, shall operate within the scope of the rules for volunteer ombudsmen promulgated by the office of long-term care ombudsman and Iowa department on aging.

[ARC 1205C, IAB 12/11/13, effective 1/15/14]

481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

58.28(1) Fire safety.

a. All nursing facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

58.28(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

58.28(3) Resident safety.

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)

f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)

[ARC 1398C, IAB 4/2/14, effective 5/7/14]

481—58.29(135C) Resident care.

58.29(1) There shall be a readily available supply of self-help and ambulation devices such as wheelchairs, walkers, and such other devices maintained in good repair that will meet the current needs of all residents. (III)

58.29(2) The facility shall ensure that each ambulatory resident has well-fitting shoes to provide support and prevent slipping. (III)

58.29(3) Equipment for personal care shall be maintained in a safe and sanitary condition. (II, III)

58.29(4) The expiration date for sterile equipment shall be exhibited on its wrappings. (III)

58.29(5) Residents who have been known to wander shall be provided with appropriate means of identification. (II, III)

58.29(6) Electric heating pads, blankets, or sheets shall be used only on the written order of a physician, when allowed by the Life Safety Code or applicable state or local fire regulations. (II, III)

481—58.30 Rescinded, effective 7/14/82.

481—58.31(135C) Housekeeping.

58.31(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

58.31(2) Each resident unit shall be cleaned on a routine schedule. (III)

58.31(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

58.31(4) A hallway or corridor shall not be used for storage of equipment. (III)

58.31(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

58.31(6) Clothing worn by personnel shall be clean and washable. (III)

58.31(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

58.31(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

58.31(9) Polishes used on floors shall provide a nonslip finish. (III)

58.31(10) *Throw or scatter rugs shall not be permitted. (III)

*Objection. For text of Objection, see IAC Supp., Part I, 9/7/77. For text of Filed rules, 470—Chapter 58, see IAC Supp. 10/5/77.

58.31(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

58.31(12) Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

58.31(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

58.31(14) Definite procedures shall be established for training housekeeping personnel. (III)

58.31(15) Rescinded IAB 12/6/06, effective 1/10/07.

58.31(16) There shall be provisions for the cleaning and storage of housekeeping equipment and supplies for each nursing unit. (III)

58.31(17) Bathtubs, shower stalls, or lavatories shall not be used for laundering, cleaning of utensils and mops, or for storage. (III)

58.31(18) Bedside utensils shall be stored in enclosed cabinets. (III)

58.31(19) Kitchen sinks shall not be used for the cleaning of mops, soaking of laundry, cleaning of bedside utensils, nursing utensils, or dumping of wastewater. (III)

58.31(20) Personal possessions of residents which may constitute hazards to themselves or others shall be removed and stored. (III)

481—58.32(135C) Maintenance.

58.32(1) Each facility shall establish a maintenance program in writing to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. (III)

58.32(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

58.32(3) Draperies and furniture shall be clean and in good repair. (III)

58.32(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

58.32(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electrical code. (III)

58.32(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

58.32(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. Documentation of these inspections shall be available for review. (III)

58.32(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

58.32(9) The facility shall be kept free of flies, other insects, and rodents. (III)

58.32(10) Maintenance personnel.

a. A written program shall be established for the orientation of maintenance personnel. (III)

b. Maintenance personnel shall:

(1) Follow established written maintenance programs; (III)

(2) Be provided with appropriate, well-constructed, and properly maintained equipment. (III)

481—58.33(135C) Laundry.

58.33(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

58.33(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

58.33(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

58.33(4) Residents' personal laundry shall be marked with an identification. (III)

58.33(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

481—58.34(135C) Garbage and waste disposal.

58.34(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

58.34(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

58.34(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

58.34(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

58.34(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—58.35(135C) Buildings, furnishings, and equipment.

58.35(1) *Buildings—general requirements.*

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-half-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of residents' clothing. (III)

58.35(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

58.35(3) *Dining and living rooms.*

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 58.35(3) "e" are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably provided with parlor furniture, television and radio receivers in good working order, recreational material such as games, puzzles, and cards, and reading material such as current newspapers and magazines. Furnishings and equipment of the room should be such as to allow group activities. (III)

(3) Card tables or game tables shall be made available. The tables should be of a height to allow a person seated in a wheelchair to partake in the games or card playing. (III)

(4) Chairs of proper height and appropriate to their use shall be provided for seating residents at game tables and card tables. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) Dining tables and chairs shall be provided. (III)

(3) Dining tables should be so constructed that a person seated in a wheelchair can dine comfortably. (III)

(4) Tables shall be of sturdy construction with smooth, durable, nonpermeable tops that can be cleaned with a detergent sanitizing solution. (III)

(5) Dining chairs shall be sturdy and comfortable. Some arm chairs should be provided for ease of movement for some residents. (III)

(6) Residents shall be encouraged to eat in the dining room. (III)

58.35(4) Bedrooms.

a. Each resident shall be provided with a standard, single, or twin bed that is substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. Seventy-five percent of the beds shall have a spring with an adjustable head and foot section. A resident shall have the right to sleep in a chair per the resident's request and to have the bed removed from the room to allow for additional space. (III)

b. Each bed shall be equipped with the following: casters or glides unless a low bed and mattress are being used for fall precautions; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average size; and moisture-proof covers and sheets as necessary to keep the mattress and pillows dry and clean. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. Clothing shall be hung in closets or wardrobes available in each room. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve the resident's needs. Mirrors are not required if the room is located in a CCDI unit and the mirrors cause concern for the resident. (III)

m. Sturdy, adjustable overbed tables shall be provided for each resident who is unable to eat in the dining room. (III)

n. Each resident bedroom shall have a door. The door shall be the swing type and shall not swing into the corridor. (III)

58.35(5) Heating. A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

58.35(6) Water supply.

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

e. Hot and cold running water under pressure shall be available in the facility. (III)

f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department of health. (III)

58.35(7) Nonambulatory residents.

a. All nonambulatory residents shall be housed on the grade level floor. (II, III)

b. These provisions in "a" above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

481—58.36(135C) Family and employee accommodations.

58.36(1) Children under 14 years of age shall not be allowed into the service areas. (III)

58.36(2) The residents' bedrooms shall not be occupied by employees or family members of the licensee. (III)

58.36(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

58.36(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

58.36(5) In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—58.37(135C) Animals. Animals may be permitted within the facility with prior approval of the department and under controlled conditions. (III)

481—58.38(135C) Supplies.**58.38(1) Linen supplies.**

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

58.38(2) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

58.38(3) Supplies and equipment for nursing services.

a. All nursing care equipment shall be properly sanitized or sterilized before use by another resident. (II)

b. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 58.10(8) "h," 481—paragraph 59.12(10) "h," or 481—paragraph 64.12(14) "h." (I, II, III)

c. Convenient, safe storage shall be provided for bath and toilet supplies, bathroom scales, mechanical lifts, and shower chairs. (III)

d. Sanitary and protective storage shall be provided for all equipment and supplies. (III)

e. All items that must be sterilized shall be autoclaved unless sterile disposable items are furnished which are promptly disposed of after a single use. (III)

f. Supplies and equipment for nursing and personal care sufficient in quantities to meet the needs of the residents shall be provided and, as a minimum, include the following: (III)

Bath basins	Rectal tubes
Soap containers	Catheters and catheterization equipment
Denture cups	Douche nozzle
Emesis basins	Oxygen therapy equipment
Mouthwash cups	Naso-gastric feeding equipment
Bedpans	Wheelchairs
Urinals	Moisture-proof draw sheets
Enema equipment	Moisture-proof pillow covers
Commodes	Moisture-proof mattress covers

Quart graduate measure	Foot tubs
Thermometer for measurement of bath water temperature	Metal pitcher
Oral thermometer	Disinfectant solutions
Rectal thermometer	Alcohol
Basins for sterilizing thermometers	Lubricating jelly
Basins for irrigations	Skin lotion
Asepto syringes	Applicators
Sphygmomanometer	Tongue blades
Paper towels	Toilet paper
Paper handkerchiefs	Rubber gloves or disposable gloves
Insulin syringes	Scales for nonambulatory patients
2 cc hypodermic syringes	Tourniquet
Weight scales	Suction machine
Hypodermic needles	Medicine dispensing containers
Stethoscope	Bandages
Ice caps	Adhesive
Hot water bottles	Portable linen hampers
	Denture identification equipment
	Tracheotomy care equipment

481—58.39(135C) Residents' rights in general.

58.39(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

58.39(2) Policies and procedures shall address the admission and retention of persons with histories of dangerous or disturbing behavior. For the purposes of the subrule, persons with histories of dangerous or disturbing behavior are those persons who have been found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

- a. Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.
- b. Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) and which is provided in accordance with the individualized health care plan.
- c. Ongoing and documented staff training on individualized health care planning for persons with mental illness.

58.39(3) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

- a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)
- b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

58.39(4) Policies and procedures regarding the use of chemical and physical restraints shall define the use of said restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

58.39(5) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

58.39(6) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

58.39(7) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

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

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf, or blind residents of such changes. (II)

58.39(8) Each resident or responsible party shall be fully informed in a contract as required in rule 481—58.13(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges including any charges for services not covered under the Title XIX program or not covered by the facility's basic per diem rate. (II)

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 135C.23(2).
[ARC 0766C, IAB 5/29/13, effective 7/3/13]

481—58.40(135C) Involuntary discharge or transfer.

58.40(1) *Involuntary discharge or transfer permitted.* A facility may involuntarily discharge or transfer a resident for only one of the following reasons:

- a.* Medical reasons;
- b.* The resident's welfare or that of other residents;
- c.* Nonpayment for the resident's stay, as described in the contract for the resident's stay;
- d.* Due to action pursuant to Iowa Code chapter 229;
- e.* By reason of negative action by the Iowa department of human services; or
- f.* By reason of negative action by the quality improvement organization (QIO). (I, II, III)

58.40(2) *Medical reasons.* Medical reasons for transfer or discharge shall be based on the resident's needs and shall be determined and documented in the resident's record by the primary care provider. Transfer or discharge may be required in order to provide a different level of care to the resident. (II)

58.40(3) *Welfare of a resident.* Welfare of a resident or that of other residents refers to a resident's social, emotional, or physical well-being. A resident may be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Written documentation that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall include specific information to support this determination. (II)

58.40(4) *Involuntary discharge or transfer prohibited—payment source.* A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A or because the resident's source of payment is changing from private support to payment under Iowa Code chapter 249A. (I, II)

58.40(5) *Notice.* Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident and the responsible party. (II, III)

- a.* The notice shall contain all of the following information:
 - (1) The stated reason for the proposed transfer or discharge. (II)
 - (2) The effective date of the proposed transfer or discharge. (II)
 - (3) A statement, in not less than 12-point type, that reads as follows:

You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request and you will not be transferred before a final decision is rendered. Extension of the 14-day requirement may be permitted in emergency circumstances upon request to the department's designee. If you lose the hearing, you will not be transferred before the expiration of either (1) 30 days following your receipt of the original notice of the discharge or transfer, or (2) 5 days following final decision of such hearing, including the exhaustion of all appeals, whichever occurs later. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. (II)

b. The notice shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department; the resident's responsible party; the resident's primary care provider; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's office of the long-term care ombudsman. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

c. The notice required by paragraph 58.40(5) "a" shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs:

(1) An emergency transfer or discharge is mandated by the resident's health care needs and is in accordance with the written orders and medical justification of the primary care provider. Emergency transfers or discharges may also be mandated in order to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) The transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.

(3) The discharge or transfer is the result of a final, nonappealable decision by the department of human services or the QIO.

d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 58.40(7). **58.40(6) *Emergency transfer or discharge.*** In the case of an emergency transfer or discharge, the resident must be given a written notice prior to or within 48 hours following the transfer or discharge. (II, III)

a. A copy of this notice shall be placed in the resident's file. The notice shall contain all of the following information:

(1) The stated reason for the transfer or discharge. (II)

(2) The effective date of the transfer or discharge. (II)

(3) A statement, in not less than 12-point type, that reads as follows:

You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. (II)

b. The notice shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department; the resident's responsible party; the resident's primary care provider; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's office of the long-term care ombudsman. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

c. A hearing requested pursuant to this subrule shall be held in accordance with subrule 58.40(7).
58.40(7) Hearing.

a. Request for hearing.

(1) The resident must request a hearing within 7 days of receipt of the written notice.

(2) The request must be made to the department, either in writing or verbally.

b. The hearing shall be held no later than 14 days after the department's receipt of the request unless either party requests an extension due to emergency circumstances.

c. Except in the case of an emergency discharge or transfer, a request for a hearing shall stay a transfer or discharge pending a final decision, including the exhaustion of all appeals. (II)

d. The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to Iowa Code chapter 17A and 481—Chapter 10. The hearing shall be public unless the resident or resident's legal representative requests in writing that the hearing be closed. In a determination as to whether a transfer or discharge is authorized, the burden of proof by a preponderance of the evidence rests on the party requesting the transfer or discharge.

e. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the facility, the resident, the responsible party, and the office of the long-term care ombudsman not later than 5 full business days after the department's receipt of the request. The notice shall also inform the facility and the resident or the responsible party that they have a right to appear at the hearing in person or be represented by an attorney or other individual. The appeal shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The office of the long-term care ombudsman shall have the right to appear at the hearing.

f. The administrative law judge's written decision shall be mailed by certified mail to the facility, resident, responsible party, and the office of the long-term care ombudsman within 10 working days after the hearing has been concluded.

g. If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the QIO, an appeal shall be filed with those agencies as appropriate. Continued payment shall be consistent with rules of those agencies.

58.40(8) Nonpayment. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

58.40(9) Discussion of involuntary transfer or discharge. Within 48 hours after notice of involuntary transfer or discharge has been received by the resident, the facility shall discuss the involuntary transfer or discharge with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

a. The facility administrator or other appropriate facility representative serving as the administrator's designee shall provide an explanation and discussion of the reasons for the resident's involuntary transfer or discharge. (II)

b. The content of the explanation and discussion shall be summarized in writing, shall include the names of the individuals involved in the discussion, and shall be made part of the resident's record. (II)

c. The provisions of this subrule do not apply if the involuntary transfer or discharge has already occurred pursuant to subrule 58.40(6) and emergency notice is provided within 48 hours.

58.40(10) Transfer or discharge planning.

a. The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

b. To minimize the possible adverse effects of the involuntary transfer, the resident shall receive counseling services by the sending facility before the involuntary transfer and by the receiving facility after the involuntary transfer. Counseling shall be documented in the resident's record. (II)

c. The counseling requirement in paragraph 58.40(10) "b" does not apply if the discharge has already occurred pursuant to subrule 58.40(6) and emergency notice is provided within 48 hours.

d. Counseling, if required, shall be provided by a licensed mental health professional as defined in Iowa Code section 228.1(6). (II)

e. The health care facility that receives a resident who has been involuntarily transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

58.40(11) *Transfer upon revocation of license or voluntary closure.* Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of the voluntary closure of a facility, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

58.40(12) *Intrafacility transfer.*

a. Residents shall not be arbitrarily relocated from room to room within a licensed health care facility. (I, II) Involuntary relocation may occur only in the following situations, which shall be documented in the resident's record: (II)

(1) Resident's incompatibility with or disturbance to other roommates.

(2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as judged by the primary care provider, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX (Medicaid) assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in subparagraph 58.40(12) "a"(5). (II)

(2) As punishment or behavior modification, except as specified in subparagraph 58.40(12) "a"(1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph 58.40(12) "a," the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required in order to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition that necessitates emergency relocation, and such notification shall be documented. (II)

e. A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility and not as an intrafacility transfer. (II, III)

[ARC 1752C, IAB 12/10/14, effective 1/14/15]

481—58.41(135C) Residents' rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

58.41(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

58.41(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a. Designation of an employee responsible for handling grievances and recommendations. (II)
- b. A method of investigating and assessing the validity of a grievance or recommendation. (II)
- c. Methods of resolving grievances. (II)
- d. Methods of recording grievances and actions taken. (II)

58.41(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and certified volunteer long-term care ombudsman and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

[ARC 1205C, IAB 12/11/13, effective 1/15/14]

481—58.42(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

58.42(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

58.42(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

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

58.42(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge that the resident has seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

58.42(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

58.42(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

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

58.43(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

58.43(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

58.43(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

58.43(4) Physicians' orders are required to utilize all types of physical restraints and shall be renewed at least quarterly. (II) Physical restraints are defined as the following:

Type I—the equipment used to promote the safety of the individual but is not applied directly to their person. Examples: divided doors and totally enclosed cribs.

Type II—the application of a device to the body to promote safety of the individual. Examples: vest devices, soft-tie devices, hand socks, geriatric chairs.

Type III—the application of a device to any part of the body which will inhibit the movement of that part of the body only. Examples: wrist, ankle or leg restraints and waist straps.

58.43(5) Physical restraints are not to be used to limit resident mobility for the convenience of staff and must comply with life safety requirements. If a resident's behavior is such that it may result in injury to the resident or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure(s) designed to modify the behavioral problems for which the resident is restrained, or as a last resort, after failure of attempted therapy. (I, II)

58.43(6) Each time a Type II or III restraint is used documentation on the nurse's progress record shall be made which includes type of restraint and reasons for the restraint and length of time resident was restrained. The documentation of the use of Type III restraint shall also include the time of position change. (II)

58.43(7) Each facility shall implement written policies and procedures governing the use of restraints which clearly delineate at least the following:

- a. Physicians' orders shall indicate the specific reasons for the use of restraints. (II)
- b. Their use is temporary and the resident will not be restrained for an indefinite amount of time. (I, II)
- c. A qualified nurse shall make the decision for the use of a Type II or Type III restraint for which there shall be a physician's order. (II)
- d. A resident placed in a Type II or III restraint shall be checked at least every 30 minutes by appropriately trained staff. No form of restraint shall be used or applied in such a manner as to cause injury or the potential for injury and provide a minimum of discomfort to resident restrained. (I, II)
- e. Reorders are issued only after the attending physician reviews the resident's condition. (II)
- f. Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision or program. (I, II)
- g. The opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which Type II and Type III restraints are employed, except when resident is sleeping. However, when resident awakens, this shall be provided. This shall be documented each time. A check sheet may serve this purpose. (I, II)
- h. Locked restraints or leather restraints shall not be permitted except in life-threatening situations. Straight jackets and secluding residents behind locked doors shall not be employed. (I, II)
- i. Nursing assessment of the resident's need for continued application of a Type III restraint shall be made every 12 hours and documented on the nurse's progress record. Documentation shall include the type of restraint, reason for the restraint and the circumstances. Nursing assessment of the resident's need for continued application of either a Type I or Type II restraint and nursing evaluation of the resident's physical and mental condition shall be made every 30 days and documented on the nurse's progress record. (II)
- j. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room. (II)
- k. Divided doors shall be of the type that when the upper half is closed the lower section shall close. (II)
- l. Methods of restraint shall permit rapid removal of the resident in the event of fire or other emergency. (I, II)

m. The facility shall provide orientation and ongoing education programs in the proper use of restraints.

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

a. The resident's responsible party shall receive a written account of the proposed plan of the use of restraints or aversive stimuli and have an opportunity to discuss the proposal with a representative(s) of the treatment team. (II)

b. The responsible party must consent in writing prior to the use of the procedure. Consent may also be withdrawn in writing. (II)

58.43(9) Allegations of dependent adult abuse. Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)

58.43(10) and **58.43(11)** Rescinded IAB 12/11/13, effective 1/15/14.

This rule is intended to implement Iowa Code sections 135C.14, 235B.3(1), and 235B.3(11).
[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1204C, IAB 12/11/13, effective 1/15/14]

481—58.44(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

58.44(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—58.45(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

58.45(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

58.45(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

58.45(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

58.45(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

58.45(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply in emergency conditions. (II)

481—58.46(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

58.46(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

58.46(2) If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II)

58.46(3) Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

481—58.47(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

58.47(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

58.47(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a. The resident refuses to see the visitor(s). (II)
- b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

58.47(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

58.47(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

58.47(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

58.47(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

58.47(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified intellectual disabilities professional or facility administrator for refusing permission. (II)

58.47(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

481—58.48(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified intellectual disabilities professional as appropriate in the resident's record. (II)

58.48(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

58.48(2) All residents shall have the freedom to refuse to participate in these activities. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

481—58.49(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

58.49(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

58.49(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

58.49(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

58.49(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

58.49(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—58.50(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room if available. (II)

58.50(1) The facility shall provide for needed privacy in visits between spouses. (II)

58.50(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

58.50(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

481—58.51(135C) Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility.

A facility shall not require the repackaging of medications dispensed by the Veterans Administration or an institution operated by the Veterans Administration for the purpose of making the drug distribution system compatible with the system used by the facility. (II)

481—58.52(135C) Incompetent resident.

58.52(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

58.52(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—58.53(135C) County care facilities. In addition to Chapter 58 licensing rules, county care facilities licensed as nursing facilities must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

481—58.54(73GA,ch 1016) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).

58.54(1) A nursing facility which chooses to care for residents in a distinct part shall obtain a license for a CCDI unit or facility. In the case of a distinct part, this license will be in addition to its ICF license. The license shall state the number of beds in the unit or facility. (III)

a. Application for this category of care shall be submitted on a form provided by the department. (III)

b. Plans to modify the physical environment shall be submitted to the department. The plans shall be reviewed based on the requirements of 481—Chapter 61. (III)

58.54(2) A statement of philosophy shall be developed for each unit or facility which states the beliefs upon which decisions will be made regarding the CCDI unit or facility. Objectives shall be developed for each CCDI unit or facility as a whole. The objectives shall be stated in terms of expected results. (II, III)

58.54(3) A résumé of the program of care shall be submitted to the department for approval at least 60 days before a separate CCDI unit or facility is opened. A new résumé of the program of care shall be submitted when services are substantially changed. (II, III)

The résumé of the program of care shall:

a. Describe the population to be served; (II, III)

b. State philosophy and objectives; (II, III)

c. List admission and discharge criteria; (II, III)

d. Include a copy of the floor plan; (II, III)

e. List the titles of policies and procedures developed for the unit or facility; (II, III)

f. Propose a staffing pattern; (II, III)

g. Set out a plan for specialized staff training; (II, III)

h. State visitor, volunteer, and safety policies; (II, III)

i. Describe programs for activities, social services and families; (II, III) and

j. Describe the interdisciplinary care planning team. (II, III)

58.54(4) Separate written policies and procedures shall be implemented in each CCDI unit or facility. There shall be:

a. Admission and discharge policies and procedures which state the criteria to be used to admit residents and the evaluation process which will be used. These policies shall require a statement from the attending physician agreeing to the placement before a resident can be moved into a CCDI unit or facility. (II, III)

b. Safety policies and procedures which state the actions to be taken by staff in the event of a fire, natural disaster, emergency medical or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility. The facility shall identify its method for security of the unit or facility and the manner in which the effectiveness of the security system will be monitored. (II, III)

c. Program and service policies and procedures which explain programs and services offered in the unit or facility including the rationale. (III)

d. Policies and procedures concerning staff which state minimum numbers, types and qualifications of staff in the unit or facility. (II, III)

e. Policies about visiting which suggest times and ensure the residents' rights to free access to visitors. (II, III)

f. Quality assurance policies and procedures which list the process and criteria which will be used to monitor and to respond to risks specific to the residents. This shall include, but not be limited to, drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

58.54(5) Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)

58.54(6) All staff working in a CCDI unit or facility shall have training appropriate to the needs of the residents. (II, III)

a. Upon assignment to the unit or facility, everyone working in the unit or facility shall be oriented to the needs of people with chronic confusion or dementing illnesses. They shall have special training appropriate to their job description within 30 days of assignment to the unit or facility. (II, III) The orientation shall be at least six hours. The following topics shall be covered:

- (1) Explanation of the disease or disorder; (II, III)
- (2) Symptoms and behaviors of memory-impaired people; (II, III)
- (3) Progression of the disease; (II, III)
- (4) Communication with CCDI residents; (II, III)
- (5) Adjustment to care facility residency by the CCDI unit or facility residents and their families; (II, III)
- (6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it; (II, III)
- (7) Activities of daily living for CCDI residents; (II, III)
- (8) Handling combative behavior; (II, III) and
- (9) Stress reduction for staff and residents. (II, III)

b. Licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of CCDI residents. The six-hour training shall count toward the required annual in-service training. (II, III)

58.54(7) There shall be at least one nursing staff person on a CCDI unit at all times. (I, II, III)

58.54(8) The CCDI unit or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and Iowa Administrative Code 481—Chapter 50.

This rule is intended to implement 1990 Iowa Acts, chapter 1016.

481—58.55(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the physical structure of the facility, if the other business or activity meets the requirements of applicable state and federal laws, administrative rules, and federal regulations.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “f” of subrule 58.55(1). (I, II, III)

58.55(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a.* Health and safety risks for residents;
- b.* Noise created by the proposed business or activity;
- c.* Odors created by the proposed business or activity;
- d.* Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- e.* Proposed staffing for the business or activity; and
- f.* Sharing of services and staff between the proposed business or activity and the facility.

58.55(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

58.55(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

481—58.56(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A nursing facility which chooses to

provide respite care services must meet the following requirements related to respite services and must be licensed as a nursing facility.

58.56(1) A nursing facility certified as a Medicaid nursing facility or Medicare skilled nursing facility must meet all Medicaid and Medicare requirements including CFR 483.12, admission, transfer and discharge rights.

58.56(2) A nursing facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

58.56(3) Rule 481—58.40(135C) regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

58.56(4) Pursuant to rule 481—58.13(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—58.13(135C), except the requirements under subrule 58.13(7).

58.56(5) Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

481—58.57(135C) Training of inspectors.

58.57(1) Subject to the availability of funding, all nursing facility inspectors shall receive 12 hours of annual continuing education in gerontology, wound care, dementia, falls, or a combination of these subjects.

58.57(2) An inspector shall not be personally liable for financing the training required under subrule 58.57(1).

58.57(3) The department shall consult with the collective bargaining representative of the inspector in regard to the training required under this rule.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.25, 135C.32, 135C.36 and 227.4 and 1990 Iowa Acts, chapter 1016.

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◊ Two or more ARCs

¹ Effective date of 470—58.15(2) “c” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.

Effective date of 470—58.15(2) “c” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

² See IAB, Inspections and Appeals Department.

OBJECTION

At its February 13 meeting the Administrative Rules Review Committee voted the following objection: [Subrules 57.23(2)“b,” 58.26(2)“b,” 59.31(2)“b,” 63.21(3)“b,” published IAB 12/13/78]

The committee objects to the amendments to 470* IAC 57.23(2)“b,” 58.26(2)“b,” 59.31(2)“b” and 63.21(3)“b,” which strike the phrase “Twenty-five percent of the staffing may be provided by qualified volunteers. The time shall be spent in working with the organized program activity.”, on the grounds these provisions are unreasonable. It is the understanding of the committee these deletions in effect require facilities to employ a person to coordinate recreation activities. It is the feeling of the committee this would result in higher per bed costs without demonstrably improving the services rendered to the patient. Volunteers have always played a major role in health care institutions, and no evidence has been submitted indicating a decline in that role or in public interest in donating time and energy.

These amendments appear in the 12-13-78 IAB, and have been filed under the emergency provisions of chapter 17A, 1979 Code.

*Chapter 57 transferred to Inspections and Appeals[481], IAC 7/15/87.

DENTAL BOARD[650]

[Prior to 5/18/88, Dental Examiners, Board of[320]]

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TITLE I
GENERAL PROVISIONSCHAPTER 1
ADMINISTRATION

[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—1.1(153) Definitions. As used in these rules:

“Accredited school” means a dental, dental hygiene, or dental assisting education program accredited by the American Dental Association Commission on Dental Accreditation.

“Board” means the board of dental examiners.

“Chapter” means Iowa Code chapter 153.

“Coronal polish” means an adjunctive procedure that must also include removal of any calculus, if present, by a dentist or dental hygienist. Coronal polishing of teeth using only a rotary instrument and a rubber cup or brush for such purpose, when performed at the direction of and under the supervision of a licensed dentist, is deemed not to be the giving of prophylactic treatment.

“Dental hygiene committee,” as defined in Iowa Code section 153.33A, means the dental hygiene committee of the board of dental examiners.

“Department” means the department of public health.

“Direct supervision” means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room.

“General supervision of a dental assistant” means that a dentist has examined the patient and has delegated the services to be provided by a registered dental assistant, which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light and intraoral camera. The dentist need not be present in the facility while these services are being provided.

“General supervision of a dental hygienist” means that a dentist has examined the patient and has prescribed authorized services to be provided by a dental hygienist. The dentist need not be present in the facility while these services are being provided. If a dentist will not be present, the following requirements shall be met:

1. Patients or their legal guardians must be informed prior to the appointment that no dentist will be present and therefore no examination will be conducted at that appointment.
2. The hygienist must consent to the arrangement.
3. Basic emergency procedures must be established and in place and the hygienist must be capable of implementing these procedures.
4. The treatment to be provided must be prior prescribed by a licensed dentist and must be entered in writing in the patient record.

“Inactive status” means the status of a practitioner licensed or registered pursuant to Iowa Code chapter 153 who is not currently engaged in the practice of dentistry, dental hygiene, or dental assisting in the state of Iowa and who has paid the required renewal fee but who has not met the requirements for continuing education.

“Lapsed license,” “permit,” or “registration” means a license, permit, or registration that a person has failed to renew as required or the license, permit, or registration of a person who failed to meet stated obligations for renewal within a stated time. A person whose license, permit, or registration has lapsed continues to hold the privilege of licensure or registration in Iowa, but may not practice dentistry, dental hygiene, or dental assisting until the license, permit, or registration is reinstated.

“License” means a certificate issued to a person to practice as a dentist or dental hygienist under the laws of this state.

“Licensee” means a person who has been issued a certificate to practice as a dentist or dental hygienist under the laws of this state.

“Overpayment” means payment in excess of the required fee. Overpayment of less than \$10 received by the board shall not be refunded.

“Peer review” as defined in Iowa Code section 272C.1(7) means evaluation of professional services rendered by a licensee or registrant.

“*Peer review committee*” as defined in Iowa Code section 272C.1(8) means one or more persons acting in a peer review capacity pursuant to these rules.

“*Personal supervision*” means the dentist is physically present in the treatment room to oversee and direct all intraoral or chairside services of the dental assistant trainee and a licensee or registrant is physically present to oversee and direct all extraoral services of the dental assistant.

“*Practice of dentistry*” as defined in Iowa Code section 153.13 includes the rendering of professional services in this state as an employee or independent contractor or the rendering of any dental decisions, including diagnosing, treatment planning, determining the appropriateness of proposed dental care, or engaging in acts that constitute the practice of dentistry.

The following classes of persons shall also be deemed to be engaged in the practice of dentistry:

1. Persons publicly professing to be dentists, dental surgeons, or skilled in the science of dentistry, or publicly professing to assume the duties incident to the practice of dentistry.

2. Persons who perform examinations, diagnosis, treatment, and attempted correction by any medicine, appliance, surgery, or other appropriate method of any disease, condition, disorder, lesion, injury, deformity, or defect of the oral cavity and maxillofacial area, including teeth, gums, jaws, and associated structures and tissue, which methods by education, background, experience, and expertise are common to the practice of dentistry.

3. Persons who offer to perform, perform, or assist with any phase of any operation incident to tooth whitening, including the instruction or application of tooth whitening materials or procedures at any geographic location. For purposes of this paragraph, “tooth whitening” means any process to whiten or lighten the appearance of human teeth by the application of chemicals, whether or not in conjunction with a light source.

“*Registrant*” means a person who has been issued a certificate to practice as a dental assistant under the laws of this state.

“*Registration*” means a certificate issued to a person to practice as a dental assistant under the laws of this state.

This rule is intended to implement Iowa Code sections 147.1(2), 147.13, 147.30, 147.76, 147.80, 153.13 and 153.15, and chapter 272C.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 2030C, IAB 6/10/15, effective 7/15/15]

650—1.2(17A,147,153,272C) Purpose of the board. The purpose of the board is to protect public health, safety, and welfare by administering, interpreting, and enforcing the provisions of law that relate to the practice of dentistry, dental hygiene, and dental assisting. In pursuit of this mission, the board performs these primary functions:

1.2(1) Administers examinations for the testing of dentists, dental hygienists, and dental assistants;

1.2(2) Issues licenses, registrations, certificates, and permits to qualified practitioners;

1.2(3) Sets standards for license, registration, and permit renewal and continuing education;

1.2(4) Enforces Iowa laws regulating the practice of dentistry, dental hygiene, and dental assisting;

1.2(5) Investigates complaints concerning violations of the dental practice Act and rules;

1.2(6) Conducts disciplinary hearings and monitors the compliance of licensees or registrants with board orders; and

1.2(7) Adopts rules and establishes standards for practitioners pursuant to its authority under the Iowa Code and administrative rules.

650—1.3(17A,147,153) Organization of the board.

1.3(1) The board shall be composed of five members licensed to practice dentistry, two members licensed to practice dental hygiene and two members not licensed to practice dentistry or dental hygiene and who shall represent the general public. All members are appointed by the governor, subject to confirmation by the senate.

1.3(2) Five members of the board shall constitute a quorum for the purpose of conducting business.

1.3(3) The dental hygiene committee of the board shall be composed of the two dental hygiene members of the board and one dentist member of the board. The dentist member will be elected annually

to serve on the committee by a majority vote of the board. The dentist member of the committee must have supervised and worked in collaboration with a dental hygienist for a period of at least three years immediately preceding election to the committee.

1.3(4) Two members of the dental hygiene committee shall constitute a quorum for the purpose of conducting business.

1.3(5) Committees of the board may be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include the executive committee, licensure committee, grievance committee, continuing education advisory committee, and dental assistant committee.

650—1.4(153) Organization of the dental hygiene committee.

1.4(1) All matters regarding the practice, discipline, education, examination, and licensure of dental hygienists will be initially directed to the dental hygiene committee. The committee shall have the authority to adopt recommendations regarding the practice, discipline, education, examination, and licensure of dental hygienists and shall carry out duties as assigned by the board. Recommendations by the committee shall include a statement and documentation supporting its recommendation to the board. The board shall review all committee recommendations. The recommendations shall be ratified by the board unless the board makes a specific written finding that the recommendation exceeds the jurisdiction or expands the scope of the committee beyond the authority granted in subrule 1.4(2), creates an undue financial impact on the board, or is not supported by the record. The board may not amend a committee recommendation without the concurrence of the majority of the members of the dental hygiene committee.

1.4(2) This rule shall not be construed as impacting or changing the scope of practice of the profession of dental hygiene or authorizing the independent practice of dental hygiene.

1.4(3) The committee shall not have regulatory or disciplinary authority with regard to dentists, dental assistants, dental lab technicians, or other auxiliary dental personnel.

This rule is intended to implement Iowa Code section 153.33A.

650—1.5(17A,153) Information. Members of the public may obtain information from or submit requests relating to the practice of dentistry, dental hygiene, or dental assisting, continuing education, or any other matter to the Executive Director, Iowa Board of Dental Examiners, 400 SW 8th Street, Suite D, Des Moines, Iowa 50309-4687.

650—1.6(17A,147,153) Meetings.

1.6(1) The board shall hold an annual meeting each year in Des Moines to elect officers and conduct other business. Officers of the board shall consist of a chairperson, vice chairperson, and secretary. Officers shall assume their duties immediately following their election at the annual meeting.

1.6(2) The board may hold additional meetings as the chairperson, vice chairperson, or majority of the board deems necessary. Written notices stating the time and place of the meetings shall be provided consistent with the open meetings law.

1.6(3) The dental hygiene committee shall hold an annual meeting each year in Des Moines, Iowa, to elect officers and conduct other business. Officers of the committee shall consist of a chairperson, vice chairperson, and secretary. Officers shall assume their duties immediately following their election at the annual meeting.

1.6(4) The dental hygiene committee may hold additional meetings as the chairperson, vice chairperson, or majority of the committee deems necessary.

1.6(5) Dates and location of board meetings may be obtained from the board's office. Except as otherwise provided by statute, all board meetings shall be open and the public shall be permitted to attend.

These rules are intended to implement Iowa Code sections 17A.3, 147.14(4), 147.22, and 153.33A(1).

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TITLE IV
AUXILIARY PERSONNELCHAPTER 20
DENTAL ASSISTANTS

[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—20.1(153) Registration required. A person shall not practice on or after July 1, 2001, as a dental assistant unless the person has registered with the board and received a certificate of registration pursuant to this chapter.

650—20.2(153) Definitions. As used in this chapter:

“Dental assistant” means any person who, under the supervision of a dentist, performs any extraoral services including infection control or the use of hazardous materials or performs any intraoral services on patients. The term “dental assistant” does not include persons otherwise actively licensed in Iowa to practice dental hygiene or nursing who are engaged in the practice of said profession.

“Direct supervision” means that the dentist is present in the treatment facility, but it is not required that the dentist be physically present in the treatment room while the registered dental assistant is performing acts assigned by the dentist.

“General supervision” means that a dentist has examined the patient and has delegated the services to be provided by a registered dental assistant, which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light and intraoral camera. The dentist need not be present in the facility while these services are being provided.

“Personal supervision” means the dentist is physically present in the treatment room to oversee and direct all intraoral or chairside services of the dental assistant and a licensee or registrant is physically present to oversee and direct all extraoral services of the dental assistant.

“Public health supervision” means all of the following:

1. The dentist authorizes and delegates the services provided by a registered dental assistant to a patient in a public health setting, with the exception that services may be rendered without the patient’s first being examined by a licensed dentist;
2. The dentist is not required to provide future dental treatment to patients served under public health supervision;
3. The dentist and the registered dental assistant have entered into a written supervision agreement that details the responsibilities of each licensee/registrant, as specified in subrule 20.16(2); and
4. The registered dental assistant has an active Iowa registration and a minimum of one year of clinical practice experience.

“Trainee status expiration date” means the date established by the board office which is 12 months from a person’s first date of employment as a dental assistant. The trainee status expiration date is the date by which a trainee must successfully complete requirements and become registered as a dental assistant, pursuant to Iowa Code section 153.39.

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650—20.3(153) Scope of practice.

20.3(1) In all instances, a dentist assumes responsibility for determining, on the basis of diagnosis, the specific treatment patients will receive and which aspects of treatment may be delegated to qualified personnel as authorized in these rules.

20.3(2) A licensed dentist may delegate to a dental assistant those procedures for which the dental assistant has received training. This delegation shall be based on the best interests of the patient. The dentist shall exercise supervision and shall be fully responsible for all acts performed by a dental assistant. A dentist may not delegate to a dental assistant any of the following:

- a. Diagnosis, examination, treatment planning, or prescription, including prescription for drugs and medicaments or authorization for restorative, prosthodontic or orthodontic appliances.

- b. Surgical procedures on hard and soft tissues within the oral cavity and any other intraoral procedure that contributes to or results in an irreversible alteration to the oral anatomy.
- c. Administration of local anesthesia.
- d. Placement of sealants.
- e. Removal of any plaque, stain, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish, or removal of any calculus.
- f. Dental radiography, unless the assistant is qualified pursuant to 650—Chapter 22.
- g. Those procedures that require the professional judgment and skill of a dentist.

20.3(3) A dental assistant may perform duties consistent with these rules under the supervision of a licensed dentist. The specific duties dental assistants may perform are based upon:

- a. The education of the dental assistant.
- b. The experience of the dental assistant.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.4(153) Expanded function requirements.

20.4(1) *Supervision requirements.* Registered dental assistants may only perform expanded function procedures which are delegated by and performed under the direct supervision of a dentist licensed pursuant to Iowa Code chapter 153. Dental assistant trainees are not eligible to perform expanded function procedures.

20.4(2) *Expanded function training required.* A registered dental assistant shall not perform any expanded function procedures listed in this chapter unless the assistant has successfully met the education and training requirements and is in compliance with the requirements of this chapter.

20.4(3) *Education and training requirements.* All expanded function training must be prior-approved by the board. The supervising dentist and the registered dental assistant shall be responsible for maintaining in each office of practice documentation of successful completion of the board-approved training.

a. Expanded function training for Level 1 procedures shall be eligible for board approval if the training is offered through a program accredited by the Commission on Dental Accreditation of the American Dental Association (ADA) or another program, which may include on-the-job training offered by a dentist licensed in Iowa. Training must consist of the following:

(1) An initial assessment to determine the base entry level of all participants in the program. At a minimum, all participants must meet at least one of the following requirements before beginning expanded function training:

- 1. Be a graduate of an ADA-accredited dental assistant program; or
- 2. Be currently certified by the Dental Assisting National Board (DANB); or
- 3. Have at least one year of clinical practice as a registered dental assistant; or
- 4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration;

(2) A didactic component;

(3) A laboratory component, if necessary;

(4) A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and

(5) A postcourse competency assessment at the conclusion of the training program.

b. Expanded function training for Level 2 procedures shall be eligible for board approval if the training is offered through the University of Iowa College of Dentistry or a program accredited by the Commission on Dental Accreditation of the American Dental Association.

20.4(4) *Expanded function providers.*

a. *Basic expanded function provider.* Registered dental assistants who do not wish to become certified as a Level 1 or Level 2 provider may perform select Level 1 expanded function procedures provided they have met the education and training requirements for those procedures. A dentist may delegate to a registered dental assistant only those Level 1 procedures for which the assistant has received the required expanded function training.

b. Certified Level 1 provider. Registered dental assistants must successfully complete training for all Level 1 expanded function procedures before becoming a certified Level 1 provider.

(1) A dentist may delegate any of the Level 1 expanded function procedures to dental assistants who are certified Level 1 providers.

(2) Level 1 procedures include:

1. Taking occlusal registrations;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases, desensitizing agents, and bonding systems;
5. Placement and removal of dry socket medication;
6. Placement of periodontal dressings;
7. Testing pulp vitality;
8. Monitoring of nitrous oxide inhalation analgesia;
9. Taking final impressions;
10. Removal of adhesives (hand instrumentation only); and
11. Preliminary charting of existing dental restorations and teeth.

c. Certified Level 2 provider. A registered dental assistant must become a certified Level 1 provider and successfully pass a board-approved entrance examination with a score of at least 75 percent before beginning training as a certified Level 2 provider. Registered dental assistants must successfully complete training for all Level 2 expanded function procedures before becoming certified Level 2 providers.

(1) A dentist may delegate any of the Level 1 or Level 2 expanded function procedures to a registered dental assistant who is a certified Level 2 provider.

(2) Level 2 procedures include:

1. Placement and shaping of amalgam following preparation of a tooth by a dentist;
2. Placement and shaping of composite following preparation of a tooth by a dentist;
3. Forming and placement of stainless steel crowns;
4. Taking records for the fabrication of dentures and partial dentures; and
5. Tissue conditioning (soft reline only).

These procedures refer to both primary and permanent teeth.

(3) Notwithstanding 650—paragraph 10.3(1)“e” and paragraph 20.3(2)“e,” for the purposes of this chapter, the removal of adhesives by hand instrumentation does not constitute the removal of “hard natural or synthetic material.”

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.5(153) Categories of dental assistants: dental assistant trainee, registered dental assistant. There are two categories of dental assistants. Both the supervising dentist and dental assistant are responsible for maintaining documentation of training. Such documentation must be maintained in the office of practice and shall be provided to the board upon request.

20.5(1) Dental assistant trainee. Dental assistant trainees are all individuals who are engaging in on-the-job training to meet the requirements for registration and who are learning the necessary skills under the personal supervision of a licensed dentist. Trainees may also engage in on-the-job training in dental radiography pursuant to 650—22.3(136C,153).

a. General requirements. The dental assistant trainee shall meet the following requirements:

(1) Prior to the trainee status expiration date, the dental assistant trainee shall successfully complete a course of study and examination in the areas of infection control, hazardous materials, and jurisprudence. The course of study shall be prior approved by the board and sponsored by a board-approved postsecondary school.

(2) Prior to the trainee status expiration date, the trainee must apply to the board office to be reclassified as a registered dental assistant.

(3) If a trainee fails to become registered by the trainee status expiration date, the trainee must stop work as a dental assistant.

b. New trainee application required if trainee not registered prior to trainee status expiration date. Pursuant to Iowa Code section 153.39, a person employed as a dental assistant has a 12-month period following the person's first date of employment to become registered. If not registered by the trainee status expiration date, the trainee must stop work as a dental assistant and reapply for trainee status.

(1) Reapplying for trainee status. A trainee may "start over" as a dental assistant trainee provided the trainee submits an application in compliance with subrule 20.7(1).

(2) Examination scores valid for three years. A "repeat" trainee is not required to retake an examination (jurisprudence, infection control/hazardous materials, radiography) if the trainee has successfully passed the examination within three years of the date of application. If a trainee has failed two or more examinations, the trainee must satisfy the remedial education requirements in subrule 20.11(1). The trainee status application will not be approved until the trainee successfully completes any required remedial education.

(3) New trainee status expiration date issued. If the repeat trainee application is approved, the board office will establish a new trainee status expiration date by which registration must be completed.

(4) Maximum of two "start over" periods allowed. In addition to the initial 12-month trainee status period, a dental assistant is permitted up to two start over periods as a trainee. If a trainee seeks an additional start over period beyond two, the trainee shall submit a petition for rule waiver under 650—Chapter 7.

c. Trainees enrolled in cooperative education or work study programs. The requirements stated in this subrule apply to all dental assistant trainees, including a person enrolled in a cooperative education or work-study program through an Iowa high school. In addition, a trainee under 18 years of age shall not participate in dental radiography.

20.5(2) Registered dental assistant. A registered dental assistant may perform under general supervision dental radiography, intraoral suctioning, use of a curing light and intraoral camera, and all extraoral duties that are assigned by the dentist and are consistent with these rules. During intraoral procedures, the registered dental assistant may, under direct supervision, assist the dentist in performing duties assigned by the dentist that are consistent with these rules. The registered dental assistant may take radiographs if qualified pursuant to 650—Chapter 22.

[ARC 0465C, IAB 11/28/12, effective 1/2/13; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.6(153) Registration requirements prior to July 2, 2001.

20.6(1) A person employed as a dental assistant as of July 1, 2001, shall be registered with the board as a registered dental assistant without meeting the application requirements specified in 650—20.7(153), provided the application is postmarked by July 1, 2001.

20.6(2) Applications for registration prior to July 2, 2001, must be filed on official board forms and include the following:

- a.* The fee as specified in 650—Chapter 15.
- b.* Evidence of current employment as a dental assistant as demonstrated by a signed statement from the applicant's employer.
- c.* Evidence of current certification in dental radiography pursuant to 650—Chapter 22 if engaging in dental radiography.

20.6(3) Applications must be signed and verified by the applicant as to the truth of the documents and statements contained therein.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.7(153) Registration requirements after July 1, 2001. Effective July 2, 2001, dental assistants must meet the following requirements for registration:

20.7(1) Dental assistant trainee.

- a.* On or after May 1, 2013, a dentist supervising a person performing dental assistant duties must ensure that the person has been issued a trainee status certificate from the board office prior to the person's first date of employment as a dental assistant. A dentist who has been granted a temporary permit to provide volunteer services for a qualifying event of limited duration pursuant to 650—subrule 13.3(3),

or an Iowa-licensed dentist who is volunteering at such qualifying event, is exempt from this requirement for a dental assistant who is working under the dentist's supervision at the qualifying event.

b. Applications for registration as a dental assistant trainee must be filed on official board forms and include the following:

- (1) The fee as specified in 650—Chapter 15.
- (2) Evidence of high school graduation or equivalent.
- (3) Evidence the applicant is 17 years of age or older.
- (4) Any additional information required by the board relating to the character and experience of the applicant as may be necessary to evaluate the applicant's qualifications.
- (5) If the applicant does not meet the requirements of (2) and (3) above, evidence that the applicant is enrolled in a cooperative education or work-study program through an Iowa high school.

c. Prior to the trainee status expiration date, the dental assistant trainee is required to successfully complete a board-approved course of study and examination in the areas of infection control, hazardous materials, and jurisprudence. The course of study may be taken at a board-approved postsecondary school or on the job using curriculum approved by the board for such purpose. Evidence of meeting this requirement prior to the trainee status expiration date shall be submitted by the employer dentist.

d. Prior to the trainee status expiration date, the dental assistant trainee's supervising dentist must ensure that the trainee has received a certificate of registration before performing any further dental assisting duties.

20.7(2) Registered dental assistant.

a. To meet this qualification, a person must:

- (1) Work in a dental office for six months as a dental assistant trainee; or
- (2) If licensed out of state, have had at least six months of prior dental assisting experience under a licensed dentist within the past two years; or
- (3) Be a graduate of an accredited dental assisting program approved by the board; and
- (4) Be a high school graduate or equivalent; and
- (5) Be 17 years of age or older.

b. Applications for registration as a registered dental assistant must be filed on official board forms and include the following:

- (1) The fee as specified in 650—Chapter 15.
- (2) Evidence of meeting the requirements specified in 20.7(2) "a."
- (3) Evidence of successful completion of a course of study approved by the board and sponsored by a board-approved, accredited dental assisting program in the areas of infection control, hazardous materials, and jurisprudence. The course of study may be taken at a board-approved, accredited dental assisting program or on the job using curriculum approved by the board for such purpose.
- (4) Evidence of successful completion of a board-approved examination in the areas of infection control, hazardous materials, and jurisprudence.
- (5) Evidence of high school graduation or the equivalent.
- (6) Evidence the applicant is 17 years of age or older.
- (7) Evidence of meeting the qualifications of 650—Chapter 22 if engaging in dental radiography.
- (8) A statement:
 1. Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a "hands-on" clinical component;
 2. Providing the expiration date of the CPR certificate; and
 3. Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.
- (9) Any additional information required by the board relating to the character, education and experience of the applicant as may be necessary to evaluate the applicant's qualifications.

20.7(3) Rescinded IAB 9/17/03, effective 10/22/03.

20.7(4) All applications must be signed and verified by the applicant as to the truth of the documents and statements contained therein.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 0465C, IAB 11/28/12, effective 1/2/13; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.8(153) Registration denial. The board may deny an application for registration as a dental assistant for any of the following reasons:

1. Failure to meet the requirements for registration as specified in these rules.
2. Pursuant to Iowa Code section 147.4, upon any of the grounds for which registration may be revoked or suspended as specified in 650—Chapter 30.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.9(147,153) Denial of registration—appeal procedure. The board shall follow the procedures specified in 650—11.10(147) if the board proposes to deny registration to a dental assistant applicant.

This rule is intended to implement Iowa Code sections 147.3, 147.4 and 147.29.

[ARC 7789B, IAB 5/20/09, effective 6/24/09; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.10(153) Examination requirements. Beginning July 2, 2001, applicants for registration must successfully pass an examination approved by the board on infection control, hazardous waste, and jurisprudence.

20.10(1) Examinations approved by the board are those administered by the board or board's approved testing centers or the Dental Assisting National Board Infection Control Examination, if taken after June 1, 1991, in conjunction with the board-approved jurisprudence examination. In lieu of the board's infection control examination, the board may approve an infection control examination given by another state licensing board if the board determines that the examination is substantially equivalent to the examination administered by the board.

20.10(2) Information on taking the examination may be obtained by contacting the board office at 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687.

20.10(3) An examinee must meet such other requirements as may be imposed by the board's approved dental assistant testing centers.

20.10(4) A dental assistant trainee must successfully pass the examination within 12 months of the first date of employment. A dental assistant trainee who does not successfully pass the examination within 12 months shall be prohibited from working as a dental assistant until the dental assistant trainee passes the examination in accordance with these rules.

20.10(5) A score of 75 or better on the board infection control/hazardous material exam and a score of 75 or better on the board jurisprudence exam shall be considered successful completion of the examination. The board accepts the passing standard established by the Dental Assisting National Board for applicants who take the Dental Assisting National Board Infection Control Examination.

20.10(6) The written examination may be waived by the board, in accordance with the board's waiver rules at 650—Chapter 7, in practice situations where the written examination is deemed to be unnecessary or detrimental to the dentist's practice.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.11(153) System of retaking dental assistant examinations.

20.11(1) *Second examination.*

a. On the second examination attempt, a dental assistant shall be required to obtain a score of 75 percent or better on each section of the examination.

b. A dental assistant who fails the second examination will be required to complete the remedial education requirements set forth in subrule 20.11(2).

20.11(2) *Third and subsequent examinations.*

a. Prior to the third examination attempt, a dental assistant must submit proof of additional formal education in the area of the examination failure in a program approved by the board or sponsored by a school accredited by the Commission on Dental Accreditation of the American Dental Association.

b. A dental assistant who fails the examination on the third attempt may not practice as a dental assistant in a dental office or clinic until additional remedial education approved by the board has been obtained.

c. For the purposes of additional study prior to retakes, the fourth or subsequent examination failure shall be considered the same as the third.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.12(153) Continuing education. Beginning July 1, 2001, each person registered as a dental assistant shall complete 20 hours of continuing education approved by the board during the biennium period as a condition of registration renewal.

20.12(1) At least two continuing education hours must be in the subject area of infection control.

20.12(2) A maximum of three hours may be in cardiopulmonary resuscitation.

20.12(3) For dental assistants who have radiography qualification, at least two hours of continuing education must be obtained in the subject area of radiography.

20.12(4) For the renewal period July 1, 2001, to June 30, 2003, at least one hour of continuing education must be obtained in the subject area of jurisprudence.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.13(252J,261) Receipt of certificate of noncompliance. The board shall consider the receipt of a certificate of noncompliance from the college student aid commission pursuant to Iowa Code sections 261.121 to 261.127 and 650—Chapter 34 or receipt of a certificate of noncompliance of a support order from the child support recovery unit pursuant to Iowa Code chapter 252J and 650—Chapter 33. Registration denial or denial of renewal of registration shall follow the procedures in the statutes and board rules as set forth in this rule.

This rule is intended to implement Iowa Code chapter 252J and sections 261.121 to 261.127.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.14(153) Unlawful practice. A dental assistant who assists a dentist in practicing dentistry in any capacity other than as a person supervised by a dentist in a dental office, or who directly or indirectly procures a licensed dentist to act as nominal owner, proprietor or director of a dental office as a guise or subterfuge to enable such dental assistant to engage directly or indirectly in the practice of dentistry, or who performs dental service directly or indirectly on or for members of the public other than as a person working for a dentist shall be deemed to be practicing dentistry without a license.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.15(153) Advertising and soliciting of dental services prohibited. Dental assistants shall not advertise, solicit, represent or hold themselves out in any manner to the general public that they will furnish, construct, repair or alter prosthetic, orthodontic or other appliances, with or without consideration, to be used as substitutes for or as part of natural teeth or associated structures or for the correction of malocclusions or deformities, or that they will perform any other dental service.

[ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 2028C, IAB 6/10/15, effective 7/15/15]

650—20.16(153) Public health supervision allowed. A dentist may provide public health supervision to a registered dental assistant if the dentist has an active Iowa license and the services are provided in a public or private school, public health agencies, hospitals, or the armed forces.

20.16(1) Public health agencies defined. For the purposes of this rule, public health agencies include programs operated by federal, state, or local public health departments.

20.16(2) Responsibilities. When working together in a public health supervision relationship, a dentist and registered dental assistant shall enter into a written agreement that specifies the following responsibilities.

a. The dentist providing public health supervision must:

(1) Be available to provide communication and consultation with the registered dental assistant;

(2) Have age- and procedure-specific standing orders for the performance of services. Those standing orders must include consideration for medically compromised patients and medical conditions for which a dental evaluation must occur prior to the provision of services;

(3) Specify a period of time in which an examination by a dentist must occur prior to providing further services;

(4) Specify the location or locations where the services will be provided under public health supervision.

b. A registered dental assistant providing services under public health supervision may only provide services which are limited to all extraoral duties, dental radiography, intraoral suctioning, and use of a curing light and intraoral camera and must:

(1) Maintain contact and communication with the dentist providing public health supervision;

(2) Practice according to age- and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient;

(3) Ensure that the patient, parent, or guardian receives a written plan for referral to a dentist;

(4) Ensure that each patient, parent, or guardian signs a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services; and

(5) Ensure that a procedure is in place for creating and maintaining dental records for the patients who are treated, including where these records are to be located.

c. The written agreement for public health supervision must be maintained by the dentist and the registered dental assistant and a copy filed with the board office within 30 days of the date on which the dentist and the registered dental assistant entered into the agreement. The dentist and registered dental assistant must review the agreement at least biennially.

d. The registered dental assistant shall file annually with the supervising dentist and the bureau of oral and health delivery systems a report detailing the number of patients seen, the services provided to patients and the infection control protocols followed at each practice location.

e. A copy of the written agreement for public health supervision shall be filed with the Bureau of Oral and Health Delivery Systems, Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

20.16(3) Reporting requirements. Each registered dental assistant who has rendered services under public health supervision must complete a summary report at the completion of a program or, in the case of an ongoing program, at least annually. The report shall be filed with the bureau of oral and health delivery systems of the Iowa department of public health on forms provided by the department and shall include information related to the number of patients seen and services provided so that the department may assess the impact of the program. The department will provide summary reports to the board on an annual basis.

[ARC 2028C, IAB 6/10/15, effective 7/15/15]

These rules are intended to implement Iowa Code chapter 153.

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 520
REGULATIONS APPLICABLE TO CARRIERS
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 8]

761—520.1(321) Safety and hazardous materials regulations.

520.1(1) Regulations.

a. Motor carrier safety regulations. The Iowa department of transportation adopts the Federal Motor Carrier Safety Regulations, 49 CFR Parts 385 and 390-399 (October 1, 2014).

b. Hazardous materials regulations. The Iowa department of transportation adopts the Federal Hazardous Materials Regulations, 49 CFR Parts 107, 171-173, 177, 178, and 180 (October 1, 2014).

c. Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at <http://www.fmcsa.dot.gov>.

520.1(2) Carriers subject to regulations.

a. Operators of commercial vehicles, as defined in Iowa Code section 321.1, are subject to the Federal Motor Carrier Safety Regulations adopted in this rule unless exempted under Iowa Code section 321.449.

b. Operators of vehicles transporting hazardous materials in commerce are subject to the Federal Hazardous Materials Regulations adopted in this rule unless exempted under Iowa Code section 321.450.

c. Operators of vehicles for hire, designed to transport 7 or more persons, but fewer than 16, including the driver, must comply with 49 CFR Part 395 of the Federal Motor Carrier Safety Regulations. In addition, operators of vehicles for hire designed to transport 7 or more persons, but fewer than 16, including the driver, are not exempt from logbook requirements afforded the 100-air-mile radius driver under 49 CFR 395.1(e). However, the provisions of 49 CFR Part 395 shall not apply to vehicles offered to the public for hire that are used principally in intracity operation and are regulated by local authorities.

520.1(3) Declaration of knowledge of regulations. Operators of commercial vehicles who are subject to the regulations adopted in this rule shall at the time of application for authority to operate in Iowa or upon receipt of their Iowa registration declare knowledge of the Federal Motor Carrier Safety Regulations and Federal Hazardous Materials Regulations adopted in this rule.

This rule is intended to implement Iowa Code sections 321.1, 321.449 and 321.450.

[ARC 7750B, IAB 5/6/09, effective 6/10/09; ARC 8720B, IAB 5/5/10, effective 6/9/10; ARC 9493B, IAB 5/4/11, effective 6/8/11; ARC 0034C, IAB 3/7/12, effective 4/11/12; ARC 0660C, IAB 4/3/13, effective 5/8/13; ARC 2019C, IAB 6/10/15, effective 7/15/15]

761—520.2(321) Definitions. The following definitions apply to the regulations adopted in rule 761—520.1(321):

“Any requirements which impose any restrictions upon a person” as used in Iowa Code section 321.449(6) means the requirements in 49 CFR Parts 391 and 395.

“Driver age qualifications” as used in Iowa Code section 321.449(3) means the age qualifications in 49 CFR 391.11(b)(1).

“Driver qualifications” as used in Iowa Code section 321.449(2) means the driver qualifications in 49 CFR Part 391.

“Farm customer” as used in Iowa Code section 321.450(3) means a retail consumer residing on a farm or in a rural area or city with a population of 3000 or less.

“Hours of service” as used in Iowa Code section 321.449(2) means the hours of service requirements in 49 CFR Part 395.

“Record-keeping requirements” as used in Iowa Code section 321.449(2) means the record-keeping requirements in 49 CFR Part 395.

“Rules adopted under this section concerning physical and medical qualifications” as used in Iowa Code sections 321.449(5) and 321.450(2) means the regulations in 49 CFR 391.11(b)(4) and 49 CFR Part 391, Subpart E.

“Rules adopted under this section for a driver of a commercial vehicle” as used in Iowa Code section 321.449(4) means the regulations in 49 CFR Parts 391 and 395.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

[ARC 2019C, IAB 6/10/15, effective 7/15/15]

761—520.3(321) Motor carrier safety regulations exemptions.

520.3(1) The following intrastate vehicle operations are exempt from the motor carrier safety regulations concerning inspection in 49 CFR Part 396.17 as adopted in rule 761—520.1(321):

- a. Implements of husbandry including nurse tanks as defined in Iowa Code section 321.1.
- b. Special mobile equipment (SME) as defined in Iowa Code section 321.1.
- c. Unregistered farm trailers as defined in rule 761—400.1(321), pursuant to Iowa Code section 321.123.
- d. Motor vehicles registered for a gross weight of five tons or less when used by retail dealers or their employees to deliver hazardous materials, fertilizers, petroleum products and pesticides to farm customers.

520.3(2) Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.123, 321.449 and 321.450.
[ARC 2019C, IAB 6/10/15, effective 7/15/15]

761—520.4(321) Hazardous materials exemptions. These exemptions apply to the regulations adopted in rule 761—520.1(321):

520.4(1) Pursuant to Iowa Code section 321.450(3), “retail dealers of fertilizers, petroleum products, and pesticides and their employees while delivering fertilizers, petroleum products, and pesticides to farm customers within a one-hundred-mile radius of their retail place of business” are exempt from 49 CFR 177.804; and, pursuant to Iowa Code section 321.449(4), they are exempt from 49 CFR Parts 391 and 395. However, pursuant to Iowa Code section 321.449, the retail dealers and their employees under the specified conditions are subject to the regulations in 49 CFR Parts 390, 392, 393, 396 and 397.

520.4(2) Rescinded IAB 3/10/99, effective 4/14/99.

This rule is intended to implement Iowa Code section 321.450.
[ARC 2019C, IAB 6/10/15, effective 7/15/15]

761—520.5(321) Safety fitness.

520.5(1) *New motor carrier safety audits.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform safety audits of new motor carriers and shall have the authority to enter a motor carrier’s place of business for the purpose of performing these audits. These audits shall be performed in compliance with 49 CFR Part 385 and shall be completed within 18 months from the day the motor carrier commences business.

520.5(2) *Motor carrier compliance reviews.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform compliance reviews of motor carriers and shall have the authority to enter a motor carrier’s place of business for the purpose of performing these compliance reviews. These compliance reviews shall be performed in compliance with 49 CFR Part 385.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.6(321) Out-of-service order. A person shall not operate a commercial vehicle or transport hazardous material in violation of an out-of-service order issued by an Iowa peace officer. An out-of-service order for noncompliance shall be issued when either the vehicle operator is not qualified to operate the vehicle or the vehicle is unsafe to be operated until required repairs are made. The out-of-service order shall be consistent with the North American Uniform Out-of-Service Criteria.

This rule is intended to implement Iowa Code sections 321.3, 321.208A, 321.449, and 321.450.

761—520.7(321) Driver’s statement. A “driver” as used in Iowa Code sections 321.449(5) and 321.450(2) shall carry at all times a notarized statement of employment. The statement shall include the following:

1. The driver’s name, address and social security number;
2. The name, address and telephone number of the driver’s pre-July 29, 1996, employer;
3. A statement, signed by the pre-July 29, 1996, employer or the employer’s authorized representative, that the driver was employed to operate a commercial vehicle only in Iowa; and

4. A statement showing the driver's physical or medical condition existed prior to July 29, 1996.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

[ARC 2019C, IAB 6/10/15, effective 7/15/15]

761—520.8(321) Planting and harvesting periods. In accordance with the provisions of 49 CFR 395.1, the planting and harvesting periods pertaining to agricultural operations are March 15 through June 30 and October 4 through December 14.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

[ARC 2019C, IAB 6/10/15, effective 7/15/15]

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- ¹ Effective date of 520.1(1)“a” and “b”; rescission of 520.1(2)“b”; and 520.3 delayed until adjournment of the 1993 Regular Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 14, 1992; delay lifted by the Committee November 10, 1992.